

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

Monday, December 12, 2022 – 5:30 pm

El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

PURSUANT TO GOVERNMENT CODE SECTION 54953(e)(1), EI CAMINO HEALTH **WILL NOT BE PROVIDING A PHYSICAL LOCATION TO THE PUBLIC FOR THIS MEETING**. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 921 1765 7202#. No participant code. Just press #.

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	Carol Somersille, MD Quality Committee Chair		5:30 – 5:33pm
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Carol Somersille, MD Quality Committee Chair		information 5:33 – 5:34
3. PUBLIC COMMUNICATION	Carol Somersille, MD Quality Committee Chair		information 5:34 – 5:37
4. CONSENT CALENDAR ITEMS <i>Any Committee Member or member of the public may pull an item for discussion before a motion is made.</i>	Carol Somersille, MD Quality Committee Chair	<i>public comment</i>	motion required 5:37 – 5:52
Approval a. Minutes of the Open Session of the Quality Committee Meeting (11/07/2022) Information b. Report on Board Actions c. Progress against FY23 Committee Goals d. FY23 Enterprise Quality Dashboard e. QC Follow-Up Items			
5. CHAIR’S REPORT	Carol Somersille, MD Quality Committee Chair		information 5:52 – 5:57
6. PATIENT STORY	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer		discussion 5:57 – 6:07
7. PATIENT EXPERIENCE – 5 YEAR ANALYSIS	Christine Cunningham, Chief Experience Officer		discussion 6:07 – 6:27
8. PSI REPORT	Lyn Garrett, MHA, MS, CPHQ Senior Director, Quality		discussion 6:27 - 6:37

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) 988-7609** 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
9. <u>SEPSIS MORTALITY INDEX</u>	Jessica Harkey, Manager, Sepsis Quality Daniel Shin, MD Director, Medical Quality		discussion 6:37 – 6:52
10. QUALITY COMMITTEE CANDIDATE CONSIDERATIONS & APPOINTMENT a. <u>Terhilda Garrido</u> b. <u>Pancho Chang</u>	Carol Somersille, MD Quality Committee Chair	<i>public comment</i>	motion required 6:52 – 7:12
11. ADJOURN TO CLOSED SESSION	Carol Somersille, MD Quality Committee Chair	<i>public comment</i>	motion required 7:12 – 7:13
12. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Carol Somersille, MD Quality Committee Chair		information 7:13 – 7:14
13. CONSENT CALENDAR <i>Any Committee Member may pull an item for discussion before a motion is made.</i> Approval <i>Gov't Code Section 54957.2.</i> a. Minutes of the Closed Session of the Quality Committee Meeting (11/07/2022) b. Quality Council Minutes (11/02/2022)	Carol Somersille, MD Quality Committee Chair		motion required 7:14 – 7:19
14. <i>Health and Safety Code Section 32155</i> SERIOUS SAFETY/RED ALERT EVENT	Holly Beeman, MD, MBA, Chief Quality Officer		discussion 7:19 – 7:24
15. ADJOURN TO OPEN SESSION	Carol Somersille, MD Quality Committee Chair		motion required 7:24 - 7:25
16. RECONVENE OPEN SESSION/ REPORT OUT To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair		information 7:25 – 7:26
17. CLOSING WRAP UP	Carol Somersille, MD Quality Committee Chair		discussion 7:26 – 7:29
18. ADJOURNMENT	Carol Somersille, MD Quality Committee Chair	<i>public comment</i>	motion required 7:29– 7:30 pm

Next Meeting: February 6, 2023, March 6, 2023, April 3, 2023, May 1, 2023, June 5, 2023



**Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, November 7, 2022**

El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present

Carol Somersille, MD
Alyson Falwell**
Philip Ho, MD**
Prithvi Legha, MD**
Jack Po, MD**
Krutica Sharma, MD**
Melora Simon
John Zoglin**

Members Absent

Others Present

Dan Woods, CEO**
Holly Beeman, MD, MBA, CQO**
Meenesh Bhimani, MD, COO**
Mark Adams, MD, CMO
Cheryl Reinking, DNP, RN, CNO**
Shahab Dadjou, Interim President,
ECHMN
Shreyas Mallur, MD, ACOG
Lyn Garrett, Senior Director, Quality**
Daniel Shih, MD**
Tracy Fowler, Director, Governance
Services
Nicole Hartley, Executive Assistant II

*Ms. Simon joined the meeting in person at 5:45 pm

**via teleconference

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 5:32 pm by Chair Carol Somersille. A verbal roll call was taken. Ms. Simon joined at 5:45 pm. All other members were present at roll call and participated in-person or telephonically. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. PUBLIC COMMUNICATION	There were no comments from the public.	
4. CONSENT CALENDAR	<p>Chair Somersille asked if any Committee member would like to pull an item from the consent calendar.</p> <p>Mr. Zoglin requested to pull item 4a – Minutes of the Open Session of the Quality Committee Meeting (09/06/2022) and item 4g – QC Follow-Up Items.</p> <p>Ms. Falwell requested to pull item 4e – CDI Dashboard and item 4f – Core Measures.</p> <p>Chair Somersille requested to pull item 4a – Minutes of the Open Session of the Quality Committee Meeting (09/06/2022) and item 4f – Core Measures.</p> <p>Mr. Zoglin addressed item 4a – Minutes of the Open Session of the Quality Committee Meeting (09/06/2022) regarding the</p>	Consent Calendar Approved

	<p>follow up items from the minutes for agenda item number 7 – Patient Experience (HCAHPS) and asked that they be added to item 4g – QC Follow-Up Items. Ms. Hartley confirmed they would be added.</p> <p>Ms. Falwell addressed item 4e – CDI Dashboard and recognized Cornel’s Memo for an excellent summary and had a question about the MCC/CC breakdown versus the National percentile. Dr. Adams responded that the MCC/CC breakdown represents the true number MCC/CC that exists in the patient. The National 80th percentile represents the accuracy of capturing the data goal. There is no goal number for MCC/CC. Dr. Beeman acknowledged that changes need to be made with presenting this data and that for the next biannual CDI report to the Committee, the CDI metrics and targets will be refreshed.</p> <p>Ms. Falwell addressed item 4f – Core Measures. Ms. Falwell asked about OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke, why are we performing poorly in the area we are typically successful in, and how are we going to get from 60% to 100%. Additionally, are there things that we have learned in other areas where we have improved in the Enterprise that can be applied to this area of opportunity? Dr. Beeman recommended that we add this to the follow up items and she will report out at the next Quality Committee Meeting.</p> <p>Chair Somersille addressed item 4f – Core Measures and asked about ED imaging turnaround time and the OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke. Dr. Beeman shared for ED Imaging she will discuss this more during the STEEEP agenda item but that volume and acuity play a big role in this measure. OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke will be a follow up item for the next meeting.</p> <p>Chair Somersille addressed item 4a – Minutes of the Open Session of the Quality Committee Meeting (09/06/2022) and requested to add the following:</p> <p>Agenda item 5 – Chair’s Report.</p> <p>She emphasized that:</p> <ul style="list-style-type: none">• 2/3 of body language is nonverbal• Body language cannot be assessed by ZOOM• In person attendance helps build relationships, maintain focus, and capture full attention <p>Agenda item 9 – Health Equity Metrics.</p> <p>Chair Somersille stated that the most recent Santa Clara County Census Bureau statistics available to all via the internet state that 25% of Santa Clara County is Hispanic. Although that is not a race, it is tracked and should be included.</p>	<p><i>Action: Nicole to add Follow Up items from 9/6 meeting, Agenda item 7 to the QC follow-ups document.</i></p> <p><i>Action: Dr. Beeman to provide a follow up on the OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke measure.</i></p>
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	<p>Motion: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (09/06/2022); For information: (b) Report on Board Actions, (c) FY23 Pacing Plan, (d) FY23 Enterprise Quality Dashboard, (e) CDI Dashboard, (f) Core Measures, (g) QC Follow-Up items, (h) Article of Interest</p> <p>Movant: Zoglin Second: Falwell Ayes: Somersille, Falwell, Ho, Legha, Po, Sharma, Simon, Zoglin Noes: None Abstain: None Absent: None Recused: None</p>	
<p>5. CHAIR’S REPORT</p>	<p>Chair Somersille introduced Ms. Simon as the Vice-Chair of the Quality Committee and our new Director of Governance Services, Tracy Fowler.</p> <p>Chair Somersille read the ECH Vision statement and shared that throughout the nation, patient care is evolving to more outpatient care versus inpatient care. At the last Quality Committee meeting, Chair Somersille stated that Christine Cunningham, Chief Experience Officer, reviewed the likelihood to refer metrics and will return to the committee in December to provide follow up on questions from her September presentation to the Committee. Chair Somersille reminded members that the Committee asked if this was the right measure to focus on and Christine shared that she was part of a Task Force that wrote a paper on the best way to assess Patient Experience. This document is included in the packet. Chair Somersille addressed the call to action items at the end of the article and asked the Committee to please read the article and come prepared with thoughtful questions for Christine Cunningham for the December meeting.</p> <p>Additionally, Chair Somersille shared an update on the Quality Committee recruitment efforts.</p>	
<p>6. PATIENT STORY</p>	<p>Cheryl Reinking, CNO shared feedback from a patient’s daughter who has received care at the El Camino Cancer Center. The comments shared are about the staff, Dr. Singhal, and Roksaneh who made a positive impression on this patient, especially in coordinating very complicated cancer care. The nurse mentioned often in the letter is the Cancer Center nurse coordinator. The family noticed the way in which the patient was greeted, how clinical information was communicated, and how the communication was delivered, with compassion and empathy. The family was very pleased with the care and communication provided to her mother, a true reflection of the standards of excellence at the ECH Cancer Center.</p> <p>Chair Somersille asked if Cheryl could answer the questions proposed in the memo. Cheryl addressed both questions.</p>	

	<p>1. How do you share positive feedback with the staff involved as well as recognize the entire program?</p> <p>The staff is acknowledged in many ways. Huddles, celebrate them on the unit, potential daisy award nomination, potential employee of the month nomination and more.</p> <p>2. What training do you provide to staff on WeCare standards and does the Cancer Center staff have the same training program as other staff in the enterprise?</p> <p>We have a WeCare message of the month and each week this WeCare message is reviewed during each unit's Huddle to help embed the values and standards with the staff.</p>	
<p>7. SAFETY REPORT FOR THE ENVIRONMENT OF CARE</p>	<p>Ken King, Chief Administrative Services Officer, presented the Safety Report for the Environment of Care and highlighted the following:</p> <ul style="list-style-type: none"> • Joint Commission Standards Manual - 158 elements of performance that we are measured on • ECH has 7 functional workgroups and 1 Emergency Management Committee • Reduction in workplace violence • Focus on training programs: Active shooter training • Updated facility risk assessments for Mountain View and Los Gatos <p>Dr. Sharma asked if there is a way for Board or Committee members to recognize staff. Cheryl Reinking responded that at any time, a Board/Committee member can write a letter to the staff but there is no official program at this time.</p> <p>Motion: To recommend the Safety Report for the Environment of Care to the Board</p> <p>Movant: Sharma Second: Legha Ayes: Somersille, Falwell, Ho, Legha, Po, Sharma, Simon, Zoglin Noes: None Abstain: None Absent: None Recused: None</p>	<p>Safety Report for the Environment of Care Approved</p>
<p>8. Q1 FY23 STEEEP DASHBOARD REVIEW</p>	<p>Dr. Holly Beeman, CQO provided an overview to supplement the materials in the packet for the Q1 FY23 STEEEP Dashboard review and highlighted the following:</p> <ul style="list-style-type: none"> • The process of updating the STEEEP dashboard measures included retiring measures that we are succeeding in and focusing on new areas of focused opportunity where we are not meeting targets. 	

	<ul style="list-style-type: none"> The Quality Council meetings help identify areas of opportunity as each program and department reports on quality measures and performance at the council. Dr. Beeman notes areas where there is suboptimal performance combined with the measure having an impact across multiple areas of the enterprise. Question received prior to the meeting: How do targets get set? Ask the stakeholders/sponsors of the measure what should the target be. Sponsors choose an incremental movement to help improve large gaps between the targets. <p>Ms. Simon expressed that the Quality Committee should be looped in next time STEEEP measures are changed. In the past, the Committee participated in the construction of the STEEEP Dashboard, which is a delegated responsibility from the Hospital Board.</p> <p>Dr. Holly Beeman agreed that in the future, the Quality Committee should be involved in the discussion and that Chair Somersille and Dr. Beeman can review the pacing plan to accommodate the review in May/June of the fiscal year going forward.</p> <p>Dr. Holly Beeman discussed how this year has been a learning year regarding Health Equity measures and would like to develop more specific Healthy Equity Metrics to help us measure Health Equity for FY24</p>	
<p>9. EL CAMINO HEALTH MEDICAL NETWORK REPORT</p>	<p>Ute Burness, RN, VP of Quality and Payer Relations presented on the El Camino Health Medical Network Report and highlighted the following:</p> <ul style="list-style-type: none"> What is new for Fiscal Year 2023 FY23 ECHMN Performance Dashboard Clinical Excellence Domain Clinical Excellence Domain – Action Step to Improve Performance <p>Ms. Simon emphasized the need for a rolling 12 months denominator so the system view and payer view can align. Ms. Simon requested we add this to the follow-up items. Ute Burness will look into this request.</p> <p>Mr. Zoglin asked what is the culture of the medical network and why would a Physician choose to work for the El Camino Health Medical Network over other places like Kaiser, Stanford, and Sutter. Shahab Dadjou responded that the culture is in transition and he will come back to the committee with a deeper answer in a few months.</p>	<p><i>Action: ECHMN Data presented in a rolling 12-months format</i></p>
<p>10. ADJOURN TO CLOSED SESSION</p>	<p>Motion: To adjourn to closed session at <u>6:42 pm.</u></p> <p>Movant: Simon Second: Falwell Ayes: Somersille, Falwell, Ho, Legha, Po, Sharma, Simon, Zoglin</p>	<p>Adjourned to closed session at 6:42 pm</p>

	Noes: None Abstain: None Absent: None Recused: None	
11. AGENDA ITEM 17: RECONVENE OPEN SESSION/REPORT OUT	<p>The open session reconvened at <u>7:23 pm</u>. Agenda items 11-16 were addressed in closed session.</p> <p>During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (09/06/2022), the Quality Council Minutes (09/07/2022), the Quality Council Minutes (10/05/2022), and the Medical Staff Credentialing and Privileges Report by unanimous vote by all committee members present.</p>	
12. AGENDA ITEM 18: CLOSING WRAP UP	No additional comments.	
13. AGENDA ITEM 19: ADJOURNMENT	Motion: To adjourn at <u>7:24 pm</u> Movant: Simon Second: Falwell Ayes: Somersille, Falwell, Ho, Legha, Po, Sharma, Simon, Zoglin Noes: None Abstain: None Absent: None Recused: None	Adjourned at 7:24 pm

Carol Somersille, MD
 Chair, Quality Committee

Prepared by: Nicole Hartley, Executive Assistant II

**EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO**

To: Quality Committee
From: Tracy Fowler, Director Governance Services
Date: December 12, 2022
Subject: Report on Board Actions

Purpose: To keep the Committee informed regarding actions taken by the El Camino Hospital and El Camino Healthcare District Boards.

Summary:

1. **Situation:** It is essential to keep the Committees informed about Board activity to provide context for Committee work. The list below is not meant to be exhaustive; still, it includes agenda items the Board voted on that are most likely to be of interest to or pertinent to 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 time we provided this report to the Quality Committee, the Hospital Board met twice and the District Board met once to swear in Directors Fung and Ting. In addition, since the Board has delegated specific authority to the Executive Compensation Committee, the Compliance and Audit Committee, and the Finance Committee, those approvals are also noted in this report.

Board/Committee	Meeting Date	Actions (Approvals unless otherwise noted)
ECH Board	November 9, 2022	<ul style="list-style-type: none"> - Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings - Credentialing and Privileges Report - Physician Services Agreement - Capital Project Request – MV Imaging Equipment Replacement and Expansion
	December 7, 2022	<ul style="list-style-type: none"> - Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings - Credentialing and Privileges Report (Board approved as Quality Committee was meeting at a date after the Board meeting) - Orthopedic Co-Management Agreement - Affiliate Covered Entity (ACE) Resolution
ECHD Board	December 5, 2022	<ul style="list-style-type: none"> - Oaths of Office taken by Directors Fung and Ting.
Finance Committee	November 21, 2022	<ul style="list-style-type: none"> - FY23 Period 3 Financial Report

Report on Board Actions
December 12, 2022

Board/Committee	Meeting Date	Actions (Approvals unless otherwise noted)
Compliance and Audit Committee	November 30, 2022	<ul style="list-style-type: none">- Affiliate Covered Entity (ACE) Designation and Policy- Modification to Physician Financial Arrangement Review and Approval Policy



FY23 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: **Holly Beeman, MD, MBA,** Chief Quality Officer (Executive Sponsor)

The CQO and Senior Director of Quality shall serve as the primary staff to support the Committee and are 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. The

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	- FY22 Achievement and Metrics for FY22 (Q1 FY23) - Review FY23 Incentive Goal recommendations for Quality, Safety and Patient Experience measures	Review management proposals; provide feedback and make recommendations to the Board
2. Review the milestones and outcome metrics of the ECH High Reliability implementation.	HRO Journey in process currently with classes underway April 2022 with plans for ongoing education throughout FY22 and FY23.	HRO: Serious Safety Event Rate and Culture of Safety Survey.
3. Reducing health care disparities is a quality priority for the enterprise	Biannual report to Quality Committee FY23	Monitor the effectiveness of ECH activities to reduce health care disparities in the individuals we serve
4. Review Quality, Patient Care and Patient Experience reports and dashboards	- Review reports per Pacing Plan timeline.	Explanation of measure methodology and benchmarks included with each report.
5. Review Board Quality STEEEP Dashboard and propose changes as appropriate	Quarterly	Review Dashboard and Recommend Changes to the Board
6. All committee members regularly attend and are engaged in committee meeting preparation and discussions	Using closing wrap up time, review quarterly at the end of the meeting	- Attend 2/3 of all meetings in person - Actively participate in discussions at each meeting

Chair: Dr. Carol Somersille

Executive Sponsor: Holly Beeman, MD, MBA, Chief Quality Officer

**El Camino Health Board of Directors
Quality, Patient Care and Patient Experience Committee Memo**

To: Quality, Patient Care and Patient Experience Committee
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: December 12, 2022
Subject: Enterprise Quality, Safety and Experience Dashboard through October 2022

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety and experience metrics and performance through October 2022 (unless otherwise noted) as demonstrated on the FY23 Enterprise Quality, Safety and Experience Dashboard.

Summary:

1. **Situation:** The Fiscal Year 2023 Enterprise Quality, Safety, and Experience dashboard is used throughout the organization to illustrate, track, and communicate a key set of metrics to align the quality, safety, and experience improvement work. These key metrics were selected based on a review of the organizational incentive goals, strategic goals, and areas of concern based on standardized benchmarks. These are not the only metrics that are tracked but represent the highest priority for the organization. This memo and the attached dashboard provide the Committee with a snapshot of the FY 2023 metrics monthly with trends over time and compared to the actual results from FY2022 and the FY 2023 targets.
2. **Authority:** The Quality, Patient Care and Patient Experience 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:** At the beginning of each fiscal year, an assessment is completed to identify specific areas for quality/performance improvement. A subset of these areas are then prioritized and designated as leading indicators to be tracked universally throughout the organization so that all clinicians—physicians included—and support staff are aligned in the improvement activities. Measures that demonstrate sustained improvement are removed (but still tracked) and others added.
4. **Assessment:** Of the hundreds of performance measures tracked and actively managed, 17 measures are reported on the FY23 Enterprise Quality Dashboard.
 - i. Hospital Acquired Condition Index. This metric is a composite of monthly weighted rates of 5 component measures. During October, the index was 1.30, which is greater (worse) than target of 0.986. The six C. difficile infections and 21 inpatient falls in October resulted in the higher (worse) index.
 1. C. Difficile Infections. In FY22 at El Camino Health Hospital (ECH), C. Diff. doubled from previous years (15 cases to 37 cases). The target for FY23 is to reduce C. Diff rates by 33% in FY23 which translates to having ≤ 34 hospital onset C. Diff infections. Areas of improvement focus to reduce C. Diff infections are three fold;
 - a. Hand hygiene

- b. Earlier and prompt collection of stool specimen for patients at risk for C Diff (based on their history and current clinical presentation).
 - c. Environmental cleaning.
 - 2. Patient Falls on Inpatient Units. This metric and how it is measured is defined by the National Database of Nursing Quality Indicators (NDNQI). FY20 # falls = 139, FY21 = 150, FY22 = 153. The target for FY23 is to have ≤ 142 falls or <12 per month. In October FY23 there were 21 patient falls on inpatient units. Two areas of focused process improvement are;
 - a. Using EPIC artificial intelligence to better predict fall risk on 4B.
 - b. Hourly rounding in Acute Rehab has shown a significant impact on decreasing falls. We are in the process of studying and spreading this successful pilot.
 - ii. Readmission Index. The ECH improvement efforts to reduce avoidable readmissions is bearing fruit as we see a readmission index of 0.99 for October and year to date, below the target of 1.0. Much of this improvement is attributed to focused communication, training, and collaboration (care coordination) with our SNF and home health partners in the community.
 - iii. Mortality Index. The trend of worsening mortality index in the first 4 months of FY23 is in-part attributed to an uptick in sepsis mortality. Of the 43 patient deaths in October, 19 (44%) were attributed to Sepsis. We have identified an opportunity to educate and partner with SNFs around early detection of new or recurrent sepsis in patients. Due to delayed recognition in the SNFs patients in October admitted (or readmitted) with a diagnosis of sepsis were sicker and experienced greater mortality. Dr. Shin (Quality Medical Director) and Jessica Harkey (manager of Sepsis Quality) will be sharing a detailed report on Sepsis Mortality during the Quality Committee Meeting on December 12, 2022.
 - iv. Patient Throughput-Median Time: Arrival to ED Departure. Enterprise ED throughput time year to date is 335 minutes, unfavorable to target of 275 minutes. Having capacity on inpatient units, radiology turnaround time, and optimizing efficiency of hand offs from ED teams to inpatient teams are areas of focus. We are currently engaging with a consultant to identify opportunities for improvement.

B. Patient Experience Measures.

- i. Maternal Child Health. FYTD performance = 71.8% of patients selecting top box on HCAPHS survey of likelihood to recommend. This is trending down and is lower than target of 81.5%. The drivers of this performance are construction noise, high volumes resulting in patients moving rooms multiple times during their stay, and delays in bringing in patients scheduled for inductions due to high volume and capacity constraints. The visitor policy

has been loosened and restrictions for families to use the kitchen and other areas of the hospital should help improve some elements of our patients experience when they come to ECH to give birth to their baby. Efforts to mitigate the construction disruption are also being deployed.

- ii. Christine Cunningham, Chief Experience Office, will be presenting information on patient experience measures and processes during the December 12, 2022 Quality Committee Meeting. She will be happy to provide more detailed information on patient experience performance during this portion of the agenda of the committee meeting.

List of Attachments

Attachment 1-- Enterprise Quality, Safety, and Experience Dashboard October 2022

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend <i>(showing at least the last 24 months of available data)</i>	FYTD or Rolling 12 Month Average	Measure Name
		Latest month	FYTD					
1	<p>*Organizational Goal</p> <p>HAC Index</p> <p><i>Latest data month: Oct, 22</i></p>	1.30	0.85	1.066	0.986 (7.5% ↓)			HAC Index: composite of monthly weighted rates of (5) component metrics listed below
2	<p>HAC component</p> <p>Clostridium Difficile Infections (C-Diff)</p> <p><i>Latest data month: Oct, 22</i></p>	6	3.25 / month	3.08 / month	2.85 / month			Clostridium Difficile Infection (C.diff)
3	<p>HAC component</p> <p>Surgical Site Infections (SSI)</p> <p><i>Latest data month: Oct, 22</i></p>	2	1.50 / month	1.50 / month	1.39 / month			Surgical Site Infections (SSI)
4	<p>HAC component</p> <p>non-ventilator Hospital-Acquired Pneumonia (nvHAP)</p> <p><i>Latest data month: Oct, 22</i></p>	5	7.75 / month	9.58 / month	8.86 / month			Non-ventilator Hospital-Acquired Pneumonia (nvHAP)

	FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend <i>(showing at least the last 24 months of available data)</i>	FYTD or Rolling 12 Month Average	Measure Name
	Latest month	FYTD					
<p>5</p> <p>HAC component NDNQI: IP Units Patient Falls</p> <p><i>Latest data month: Oct, 22</i></p>	21	11.50 / month	12.75 / month	11.79 / month			NDNQI: IP Units Patient Falls
<p>6</p> <p>HAC component HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury)</p> <p><i>Latest data month: Oct, 22</i></p>	1	0.75 / month	0.67 / month	0.62 / month			Stage 3, Stage 4 and Unstageable Hospital Acquired Pressure Injury (excludes skin failure and expired pts)
<p>7</p> <p>Serious Safety Event Rate (SSER) # of events/ FYTD rolling 12 month per 10,000 Acute Adjusted Patient Days Rate <i>***Latest data month: Aug, 22</i></p>	9	3.60 <i>(72/199772)</i>	3.10 <i>(Jul 2021 - Jun 2022)</i>	TBD			Serious Safety Event Rate (SSER)
<p>8</p> <p>Readmission Index (All Patient All Cause Readmit) Observed/Expected <i>Premier Standard Risk Calculation Mode</i> <i>***Latest data month: Sep, 22</i></p>	0.99 <i>(8.61%/8.66%)</i>	0.99 <i>(8.78%/8.60%)</i>	1.05	1.00			Readmission Index - All Patient All Cause Readmit (Observed/Expected)



FY23 Enterprise Quality, Safety, and Experience Dashboard

October 2022 (unless otherwise specified)

Month to Board Quality Committee:

December, 2022

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend (showing at least the last 24 months of available data)	FYTD or Rolling 12 Month Average	Measure Name
		Latest month	FYTD					
9	Mortality Index Observed/Expected Premier Standard Risk Calculation Mode Latest data month: Oct, 22	1.17 (2.06%/1.76%)	1.06 (1.81%/1.70%)	0.94	0.85			Mortality Index (Observed/Expected)
10	Sepsis Mortality Index (Observed over Expected) Latest data month: Oct, 22	1.55 (14.49%/9.33%)	1.13 (11.95%/10.57%)	1.03	0.98			Sepsis Mortality Index (Observed over Expected)
11	PC-01: Elective Delivery Prior to 39 weeks gestation (reported quarterly) Latest data quarter: Jun, 22	MV: 0.0% (0/27) LG: 0.0% (0/11) ENT: 0.0% (0/38)	MV: 0.4% (1/271) LG: 3.5% (3/85) ENT: 1.1% (4/356)	MV: 0.41% (1/244) LG: 0.0% (0/77) ENT: 0.3% (1/321)	1.3% (FY22 Target)			PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed
12	PC-02: Cesarean Birth (reported quarterly) Latest data quarter: Jun, 22	MV: 30.3% (44/145) LG: 20.0% (6/30) ENT: 28.6% (50/175)	MV: 27.1% (503/1,857) LG: 19.9% (83/417) ENT: 25.8% (586/2,274)	MV: 27.3% (423/1551) LG: 20.6% (72/349) ENT: 26.10% (495/1900)	23.5% (FY22 Target)			PC-02: Cesarean Birth - Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth

	FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend <i>(showing at least the last 24 months of available data)</i>	FYTD or Rolling 12 Month Average	Measure Name
	Latest month	FYTD					
<p>13 Patient Throughput-Median Time: Arrival to ED Departure</p> <p><i>Latest data month: Oct, 22</i></p>	<p>MV: 369 mins LG: 304 mins ENT: 337 mins</p>	<p>MV: 383 mins LG: 286 mins ENT: 335 mins</p>	<p>MV: 320 min LG: 259 min Ent: 290 min</p>	<p>MV: 304 min LG: 246 min Ent: 275 min</p>			<p>Patient Throughput-Median Time from Arrival to ED Departure (excludes psychiatric patients, patients expired in the ED, newborns, & transfer between sites)</p>
<p>14 *Organizational Goal IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted</p> <p><i>Latest data month: Oct, 22</i></p>	80.1	80.0	80.8	81.0			<p>Inpatient Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend.' %, Adjusted</p>
<p>15 IP MCH - HCAHPS Likelihood to Recommend, Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted</p> <p><i>Latest data month: Oct, 22</i></p>	69.6	71.8	81.3	81.5			<p>Maternal Child Health - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend.' %, Adjusted</p>
<p>16 ED Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend.' %, Adjusted</p> <p><i>Latest data month: Oct, 22</i></p>	73.9	71.1	74.5	75.0			<p>ED - Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend.' %, Adjusted</p>



FY23 Enterprise Quality, Safety, and Experience Dashboard

Month to Board Quality Committee:

October 2022 (unless otherwise specified)

December, 2022

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend <i>(showing at least the last 24 months of available data)</i>	FYTD or Rolling 12 Month Average	Measure Name																								
		Latest month	FYTD																													
17	<p>* Organizational Goal ECHMN (El Camino Health Medical Network): Likelihood to Recommend Care Provider Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Unadjusted Latest data month: Oct, 22</p>	82.7	81.5	83.2	83.4	<table border="1"> <caption>Monthly Trend Data</caption> <thead> <tr> <th>Month</th> <th>Value</th> </tr> </thead> <tbody> <tr><td>Jan-22</td><td>81.2</td></tr> <tr><td>Feb-22</td><td>83.5</td></tr> <tr><td>Mar-22</td><td>80.5</td></tr> <tr><td>Apr-22</td><td>78.2</td></tr> <tr><td>May-22</td><td>83.2</td></tr> <tr><td>Jun-22</td><td>85.7</td></tr> <tr><td>Jul-22</td><td>78.7</td></tr> <tr><td>Aug-22</td><td>82</td></tr> <tr><td>Sep-22</td><td>82.6</td></tr> <tr><td>Oct-22</td><td>82.7</td></tr> <tr><td>Target</td><td>83.4</td></tr> </tbody> </table>	Month	Value	Jan-22	81.2	Feb-22	83.5	Mar-22	80.5	Apr-22	78.2	May-22	83.2	Jun-22	85.7	Jul-22	78.7	Aug-22	82	Sep-22	82.6	Oct-22	82.7	Target	83.4	NA	ECHMD (El Camino Health Medical Network) - Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend.' %, Adjusted
Month	Value																															
Jan-22	81.2																															
Feb-22	83.5																															
Mar-22	80.5																															
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May-22	83.2																															
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Aug-22	82																															
Sep-22	82.6																															
Oct-22	82.7																															
Target	83.4																															

Notes:

- 1) SSER through Aug, 22
 - 2) Readmissions through Sep, '22
 - 3) PC-01 & PC-02 FY22 final results reported; FY23Q1 will be available after 2/1/23
 - 4) ECHMN: reflect new vendor (PG) survey results
- Updated: 11/27/22

		Comments	Definition Owner	Definition	Source
1	<p>*Organizational Goal</p> <p>HAC Index</p> <p><i>Latest data month: Oct, 22</i></p>		H. Beeman, MD	New for FY23, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (5) key inpatient safety events. The elements of the composite are weighted as noted: Falls 20%, hospital-acquired Pressure Injuries (HAPIs) 25%, non-ventilator hospital-acquired pneumonia (nvHAP) 20%, Clostridium difficile infections (C-Diff) 10%, and surgical site infections (SSIs) 25%.	See below
2	<p>HAC component</p> <p>Clostridium Difficile Infections (C-Diff)</p> <p><i>Latest data month: Oct, 22</i></p>		C. Nalesnik	<p>1) Based on NHSN defined criteria: inclusions: Inpatients, Peri-Op, Behavioral Health; exclusions: Rehab, NICU, outpatients, ED patients</p> <p>2) All positive C.diff Toxin/antigen lab tests that result on or after the patient's 4th day of hospitalization</p> <p>3) Latency: C-Diff infections may be identified up to 30 days, thus previously reported results may change.</p>	Numerator: Infection control Dept. Denominator: EPIC Report
3	<p>HAC component</p> <p>Surgical Site Infections (SSI)</p> <p><i>Latest data month: Oct, 22</i></p>		C. Nalesnik	<p>1) Based on NHSN defined criteria</p> <p>2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class"</p> <p>3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty".</p> <p>4) SSIs that are classified: "deep -incisional" and "organ-space" are reportable.</p> <p>5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.</p>	Numerator: Infection control Dept. Denominator: EPIC Report
4	<p>HAC component</p> <p>non-ventilator Hospital-Acquired Pneumonia (nvHAP)</p> <p><i>Latest data month: Oct, 22</i></p>		C. Delogramatic	<p>1) Internal metric: Inpatient non-ventilator hospital-acquired pneumonia cases.</p> <p>2) Numerator inclusions: inpatients (18+yrs) w/ a specified pneumonia diagnosis code(s) with POA (present on admission) status of "N" (acquired during the hospital encounter), that is unrelated to mechanical ventilation; monthly, cases are reviewed & confirmed by the nvHAP workgroup.</p> <p>3) Denominator EPSI patient days excluding 6070 NICU/Nursery Lvl 2, 6310/6315 MBU, 6340 Behavioral Health, 6440 IP Rehab, 6900 Pre-Op SSU, 7400 L&D, 7427 PACU</p> <p>5) Latency: periodic; corrections may change previously reported results.</p>	EPIC Clarity data warehouse; Numerator identified by nvHAP workgroup; Denominator: EPSI patient days

	Comments	Definition Owner	Definition	Source
5	<p>HAC component NDNQI: IP Units Patient Falls</p> <p><i>Latest data month: Oct, 22</i></p>	Nursing	<p>1) NDNQI metric: In or outpatient falls on an inpatient nursing unit. "Falls" in a nursery are 'drops'.</p> <p>2) Numerator inclusions: Patient falls as determined by a monthly evaluation & validation of iSAFE incident reports.</p> <p>3) Numerator exclusions: L&D, intentional falls.</p> <p>4) Denominator: EPSi acute patient days excluding: 6900 Pre-OP/SSU, 7400 L&D, 7427 PACU</p> <p>5) Formula: (# falls/patient days) * 1,000</p> <p>6) Latency: rare; corrections may change previously reported results.</p>	Numerator: Incident Reports and Staff Validation/iSafe Denominator: EPSi patient days
6	<p>HAC component HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury</p> <p><i>Latest data month: Oct, 22</i></p>	A. Aquino	<p>1) Internal metric: Inpatient Stage 3, Stage 4 & Unstageable hospital-acquired pressure injuries</p> <p>2) Numerator exclusions: Expirations, "skin failure/ Kennedy Pressure Ulcer" & prone Covid-19 patients</p> <p>3) Denominator: EPSi acute patient days excluding 6070 NICU/Nursery Lvl 2, 6900 Pre-Op SSU,7400 L&D, 7427 PACU</p> <p>4) Latency: periodic; corrections may change previously reported results.</p>	Numerator: EPIC Report and staff validation Denominator: EPSi patient days
7	<p>Serious Safety Event Rate (SSER) # of events/ FYTD rolling 12 month per 10,000 Acute Adjusted Patient Days Rate ***Latest data month: Aug, 22</p>	S. Shah	<p>1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient.</p> <p>2) Inclusions: events determined to be serious safety events per Safety Event Classification team</p> <p>3) NOTE: the count of SSE HAPIs MAY differ from internally-tracked HAPIs</p> <p>For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value <= zero.</p>	HPI Systems
8	<p>Readmission Index (All Patient All Cause Readmit) Observed/ Expected Premier Standard Risk Calculation Mode ***Latest data month: Sep, 22</p>	H. Beeman, MD	<p>1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause).</p> <p>2) Based upon Premier's Care Sciences Standard Practice risk-adjustment + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned').</p> <p>3) Numerator inclusions: Patient Type = Inpatient</p> <p>4) NOTE: Excludes cases discharged from (1) hospital, then readmitted to the other hospital w/in 30D.</p> <p>For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value <= zero.</p>	Premier Quality Advisor

		Comments	Definition Owner	Definition	Source
9	Mortality Index Observed/Expected <i>Premier Standard Risk Calculation Mode</i> Latest data month: Oct, 22		H. Beeman, MD	<p>1) Based upon Premier's Care Sciences Standard Practice RA for expected risk used by O/E ratio.</p> <p>2) Criteria: inclusion: Patient Type = Inpatient; exclusions: Patient Type = Rehab, Psychiatric or Hospice.</p> <p>For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value <= to zero.</p>	Premier Quality Advisor
10	Sepsis Mortality Index <i>(Observed over Expected)</i> Latest data month: Oct, 22		J. Harkey, H. Beeman, MD	<p>1) Numerator inclusions: Patient Type = Inpatient, Prin or 2nd diagnosis of sepsis & age 18+ yrs</p> <p>2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB)</p> <p>For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value <= zero.</p>	Premier Quality Advisor
11	PC-01: Elective Delivery Prior to 39 weeks gestation <i>(reported quarterly)</i> Latest data quarter: Jun, 22		H. Beeman, MD	<p>1) Numerator: Patients with elective deliveries</p> <p>2) Denominator: Delivered newborns with gestation weeks >= 37 to 39 weeks</p> <p>For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value <= zero.</p> <p>9/16/22 (per H. Freeman): The FY23 target for PC-01 1.5% (top 25th %ile for MDC). MCH needs to retain some ability to do medically indicated, yet not meeting criteria, early deliveries.</p>	IBM CareDiscovery Quality Measures
12	PC-02: Cesarean Birth <i>(reported quarterly)</i> Latest data quarter: Jun, 22		H. Beeman, MD	<p>1) Numerator: Patients with cesarean births</p> <p>2) Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation</p> <p>For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value <= zero.</p> <p>9/16/22 (per H. Freeman): FY23 target for PC-02 NTSV is 23.9%. Given our population (Asian average in CA was 25.2% from 07/2021-06/2022 for same nursery level CA MDC, + have significantly older population than CA), we think this is pretty aggressive.</p>	IBM CareDiscovery Quality Measures

		Comments	Definition Owner	Definition	Source
13	Patient Throughput-Median Time: Arrival to ED Departure <i>Latest data month: Oct, 22</i>		S. Singh	1) Same as CMS' ED Measure (ED 1b) "ED Arrival to ED Departure for Admitted pts. 2) Inclusions: patients who arrive via the ED 3) Exclusions: ED expirations, newborns, behavioral health patients & transfers between campuses. 4) Arrival: Patient Arrived in ED; ED Departure: Departed ED For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to 'o' if value </= zero.	iCare Report: ED Admit Measurement Summary
14	*Organizational Goal IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted <i>Latest data month: Oct, 22</i>		C. Cunningham	1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. 2) Inclusions: Inpatient nursing units; excludes: MBU. 3) Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to 'o' if value </= zero.	HCAHPS
15	IP MCH - HCAHPS Likelihood to Recommend, Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted <i>Latest data month: Oct, 22</i>		C. Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to 'o' if value </= zero.	HCAHPS
16	ED Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted <i>Latest data month: Oct, 22</i>		C. Cunningham	ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted' For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the average. LCL is set to 'o' if value </= zero.	Press Ganey

Definitions and Additional Information

	Comments	Definition Owner	Definition	Source
17	<p>* Organizational Goal ECHMN (El Camino Health Medical Network): Likelihood to Recommend Care Provider Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Unadjusted <i>Latest data month: Oct, 22</i></p>	C. Cunningham	<p>Switched Vendor NRC to PressGaney in January 2022. Started reporting in FY 23 dashboards 'Top Box, Received Date, and Unadjusted'</p> <p>For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value <= zero.</p>	Press Ganey

Notes:

- 1) SSER through Aug, 22
 - 2) Readmissions through Sep, '22
 - 3) PC-01 & PC-02 FY22 final results reported
 - 4) ECHMN: reflect new vendor (PG) survey
- Updated: 11/27/22

Quality Committee Follow-Up Items					
Item	Date Requested	Committee Member Name	Item Requested	Individual to complete the follow up	Completion Date
FY22					
1	2/7/2022	Krutica Sharma, MD	Please add the definitions back onto the Enterprise Dashboard	Dr. Holly Beeman	3/7/2022
2	2/7/2022	Krutica Sharma, MD	Please include the Red Flags for the Medical Staff Credentialing Privileges Report	Dr. Mark Adams	3/7/2022
3	3/7/2022	Julie Kliger	Follow up Discussion - Include patients in Quality Committee Meetings. Dr. Burn, Cheryl and Dr. Beeman will explore other models of this process.	Cheryl Reinking /Dr. Holly Beeman	
4	4/4/2022	Holly Beeman, MD	Update FY23 Quality Committee Goals to include: DEI, HRO	Dr. Holly Beeman	5/2/2022
5	6/6/2022	Carol Somersille, MD	FY 22 Enterprise Quality Dashboard, Dr. Somersille referenced page 14, likelihood to recommend care provider, and asked what is the average of this metric. Dr. Beeman shared that she can look into this and report back at the next meeting.	Dr. Holly Beeman	8/1/2022
FY23					
6	9/6/2022	Carol Somersille, MD	4d – Progress Against FY23 Committee Goals. She noted to correct the Chair name to her name and remove Julie Kliger’s name.	Nicole Hartley	9/7/2022
7	9/6/2022	Carol Somersille, MD	4e – QC Follow-Up Items. She noted to correct the Committee Member Name on the item dated 06/06/2022 to her name and remove Holly Beeman’s name	Nicole Hartley	9/7/2022
8	11/7/2022	John Zoglin	Please add the follow up items from the 9/6/22 Quality Committee Meeting for Agenda Item 7. Follow up items are: Present a 5-year analysis to the Committee and a status update on the deciles.	Nicole Hartley/Christine Cunningham	Will be shared at December Quality Committee Meeting.
9	11/7/2022	Alyson Falwell	Request for further explanation of Core Measure OP-23 (Imaging turnaround time for stroke patients evaluated and discharged from ED) performance as shared in Core Measure report during the Nov 2022 Quality Committee Meeting.	Dr. Holly Beeman	Please see attached memo providing follow up on OP23 included in the Dec 2022 committee packet.
10	11/7/2022	Melora Simon	Requests to display both the fiscal year to date and rolling 12 month performance results in future ECHMN quality reports.	Ute Burness	At the next ECHMN report to Quality Committee, Ute will provide both the rolling 12 month and the fiscal year results to the committee.

**EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO**

To: Quality Committee
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: December 12, 2022
Subject: Follow-Up Action Item: QC Meeting – Nov. 7, 2022: Outpatient-23 Core Measure

Purpose:

To update the Committee on the Outpatient-23 Core Measure. 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 for patients NOT admitted to the hospital.

OP-23 Outpatient stroke imaging turnaround time in the ED

OP-23 is a core measure encompassing ED efficiency for patients discharged from the ED with the principle diagnosis of stroke (hemorrhagic or ischemic). Patients with evolving or significant stroke are admitted to the hospital. OP-23 measure excludes patients admitted to the hospital with stroke.

Of the greater than 42,000 patients seen and discharged from our LG and MV Emergency Departments in FY22, ten patients met inclusion criteria for the outpatient stroke core measure (OP23).

Patients who meet criteria for outpatient stroke diagnosis are patients with vague symptoms who are initially worked up for something else, later found to have an incidental or clinically insignificant stroke on imaging. Because symptoms are so mil, or have resolved during ED stay, the clinical picture does not warrant admission and the patient is discharged 'home'. Of course, if their scan reveals something concerning and highly treatable then most are going to become inpatients and OP-23 will not apply.

FY22 Performance

Six of the ten outpatients seen and discharged from the ED in FY22 had interpretation of imaging results completed within 45 minutes of ED arrival. Our target is 100% and we achieved 60% completion within 45 minutes.

Focus for improvement

The ten patients included in the measure had mild symptoms, or symptoms not related to stroke. Non-specific and or mild symptoms, by design, do not trigger a stroke alert which results in rapid response imaging and triage. The ED, imaging, and neurosciences service line are focusing improvement efforts on the following: ED STAT head image orders need to be on the highest priority right after stroke alert orders, reading turnaround times also needs to be more efficient.

Stroke Measure Context

OP-23 outpatient stroke core measure is not factored into our participation and performance in the TJC and Get with the Guidelines stroke certification programs. As a reminder, our Los Gatos Campus is Total Joint Commission certified as a Primary Stroke Center and the MV campus as a Thrombectomy Capable Stroke Center. Both campuses continued to be recognized for outstanding and timely care of our patients with stroke.

American Heart Association's Get With The Guidelines Gold Plus Achievement Award



El Camino Health received the Get With The Guidelines Gold Plus Achievement Award, which is the American Heart Association's highest honor for proven dedication to ensuring all stroke patients have access to best practices and life-saving care.

In addition, El Camino Health received the Target: Stroke Honor Roll Elite Award. To qualify for this recognition, hospitals must meet specific criteria that reduce the time between an eligible patient's arrival at the hospital and treatment with the clot-buster alteplase.

Gold Seal of Approval from The Joint Commission for Stroke Care



To achieve this designation from The Joint Commission, El Camino Hospital demonstrated that its **Stroke Program** meets national standards and guidelines to significantly improve outcomes for stroke, the nation's third leading cause of death. With this designation, El Camino Health's Mountain View hospital has been designated as a Thrombectomy-Capable Stroke Center. El Camino Health's Los Gatos hospital is designated as a Primary Stroke Center.

**EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO**

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP, RN, NEA-BC, DiplACLM
Date: December 12, 2022
Subject: Patient Voice/Press Ganey Comment

Purpose: To provide the Committee with written patient feedback that is received via a Press Ganey comment through the patient experience survey process.

Summary:

1. **Situation:** This comment is from our Press Ganey patient comment portal from a patient undergoing a procedure at ECH. The comments are mostly positive, but part of the patient's experience was not positive, related to confusion regarding the time for arrival at the hospital for the procedure.
2. **Authority:** To provide insight into patient scheduling with ECH for procedures.
3. **Background:** This comment was written by the patient who wanted to express positive feedback about the care, but who was confused about arrival time.
4. **Assessment:** We have reviewed issues related to arrival times between the physician's offices, the MyCare portal, and our own procedural areas. If three different communications occur that are not congruent, it leads to confusion and does not contribute to a "frictionless" experience especially when patients arrive too early or late—it adds to anxiety for our patients as well.
5. **Outcomes:** We have developed a process that clarifies when to arrive at the hospital for a procedure. This process began in November. Due to changing schedules, the final schedule for procedures is typically finalized by 2:30 pm the day before the procedure. We are now calling and updating the portal for every patient scheduled to inform them of the final time of the procedure and the time of arrival along with other important information that is needed for the patient to follow clinically. Thus far, the new process is going quite well with fewer concerns and late arrivals.

List of Attachments:

1. See patient comment.

Suggested Committee Discussion Questions:

1. How do you recognize and determine the resources and priorities for those items that are brought forward by patients?

Patient Comment from Press Ganey Survey

Everything about the physicians, the staff, the procedures and care was absolutely stellar. The only issue was the arrival time given in my online MyCare documentation: the time for me to arrive for my 9:15am appointment for wire placement was given as 9:00am. I arrived at 8:30am because this did not seem to be enough time. Fortunately, my registration went smoothly and I was on time for my wire placement and for my surgery. I notified staff of the documented arrival time. They said it was an error and they would follow-up to correct the error and prevent it from happening to other patients. Thank you for my comprehensive experience of superior care in the hospital.



El Camino Health

Patient Experience Review

Quality Committee Meeting

Christine L. Cunningham CPXP, MBA

Chief Experience Officer

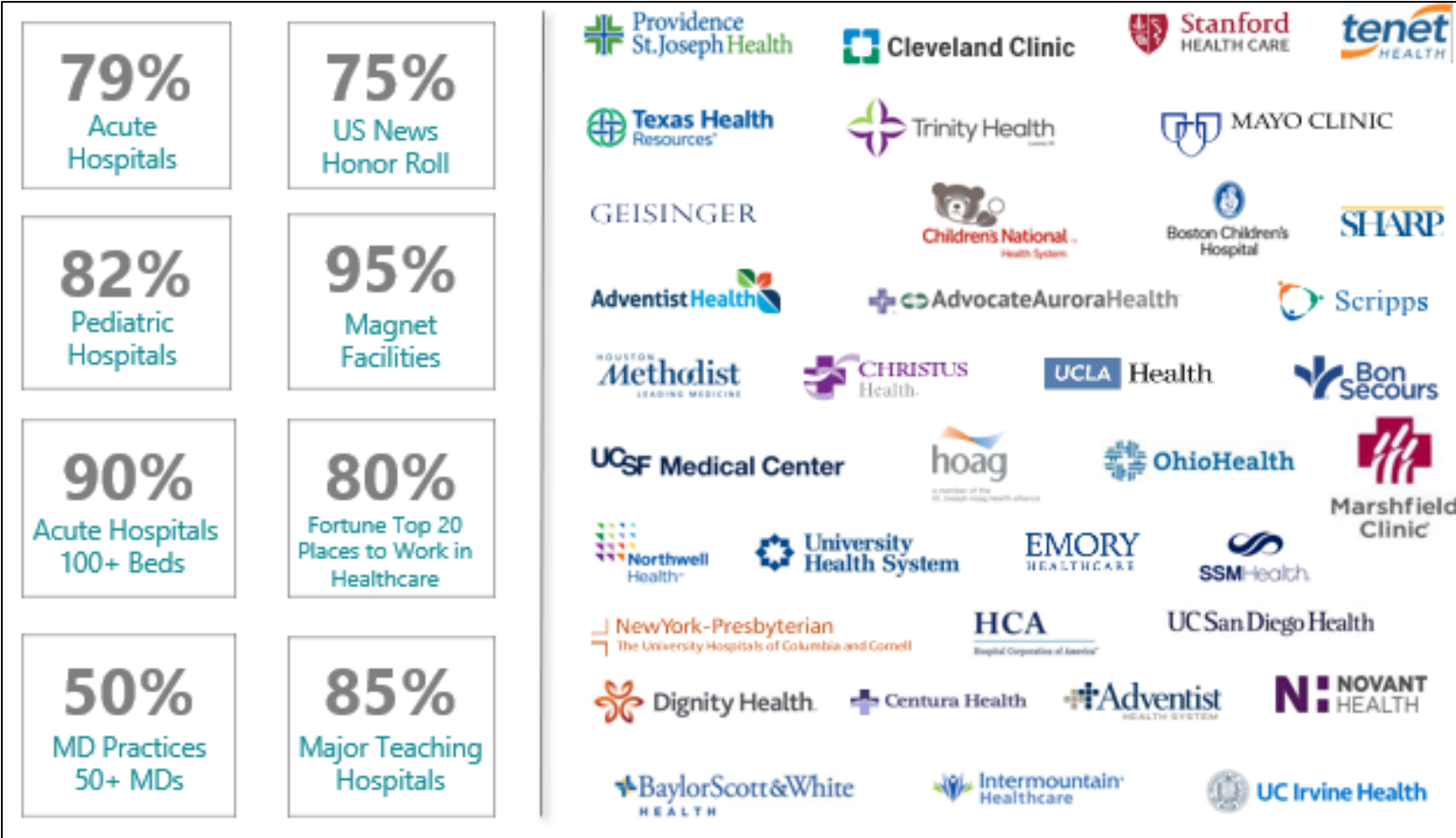
December 12th, 2022

Agenda

- Partnering with Press Ganey
- How are we performing?
- How we set goals?
- Statistical Significance

Partnering with Press Ganey

- Our partner to help with healthcare transformation
 - Integrated solutions
 - Unrivaled benchmarking



Partnering with Press Ganey

LEADERS IN REGULATORY COMPLIANCE

How Press Ganey creates and delivers advantage



40+ YEARS

Press Ganey experts have over 40 combined years of experience in health policy and regulatory data analysis.



10,400 CLIENTS

We are the largest CAHPS administrator in the country, partnering with more than 10,400 clients to measure HCAHPS, ACO CAHPS, MIPS CAHPS, HHCAHPS, Hospice CAHPS, ICH CAHPS, OAS CAHPS, and PCF PECS.



70%

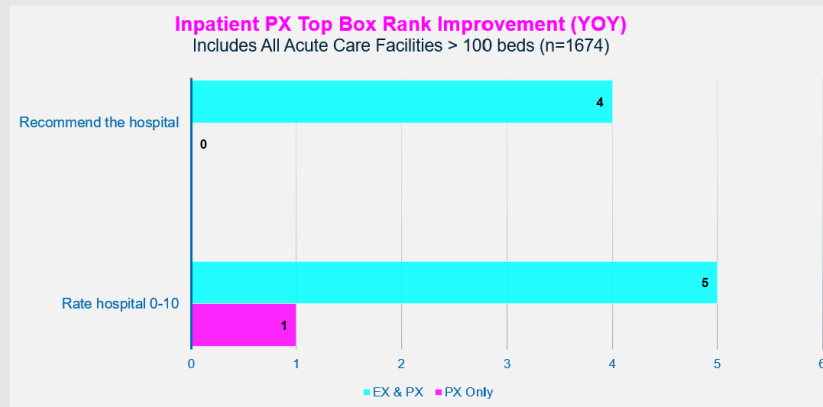
Over 70% of all U.S. acute care hospitals use Press Ganey for HCAHPS.



CLIENTS WHO TAKE AN INTEGRATED APPROACH IMPROVE YOY PERFORMANCE AT A GREATER RATE

Clients who use PG Employee Experience along with PG Patient Experience, improve YOY performance more than clients who only use Patient Experience:

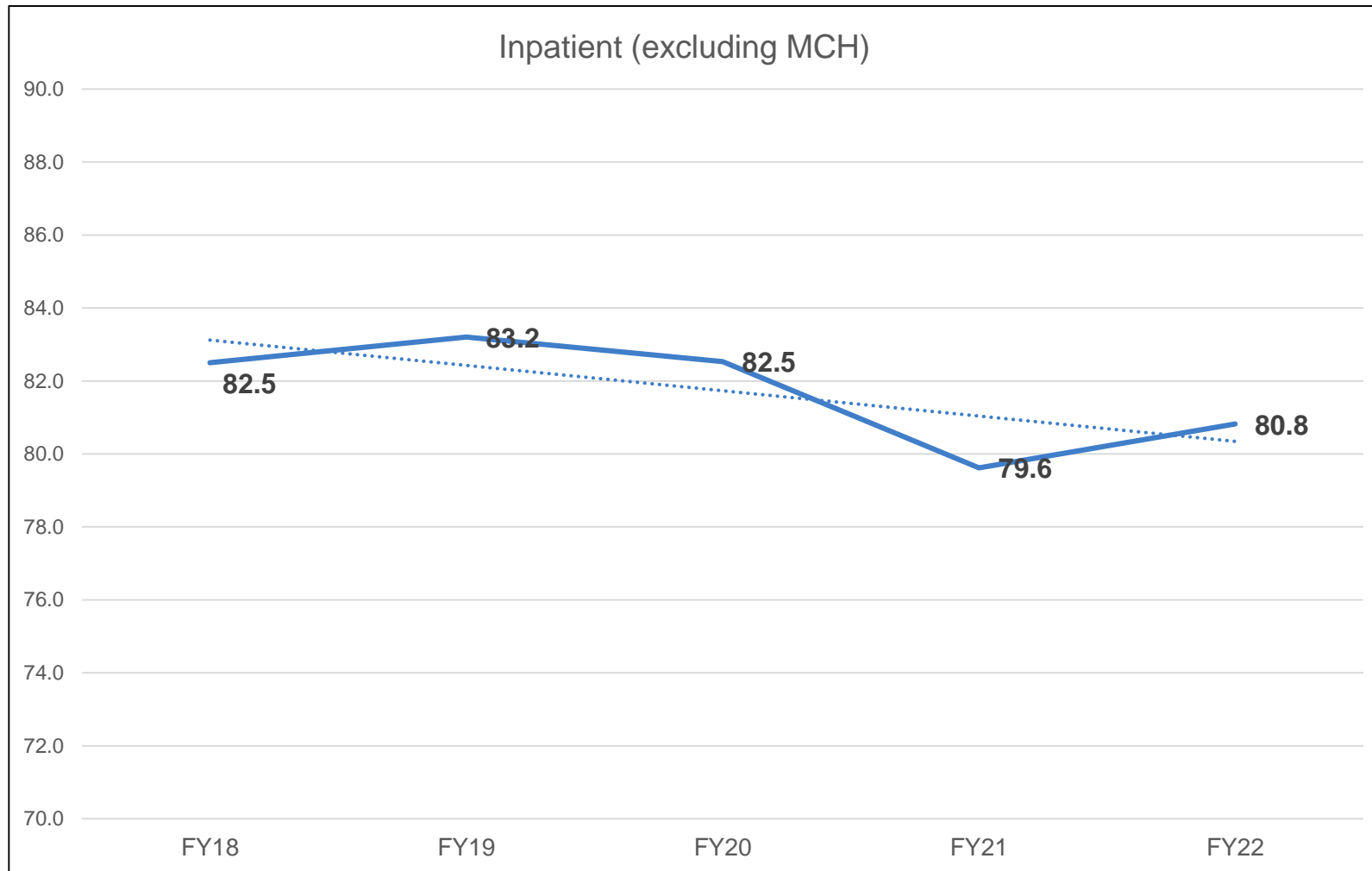
- ▲ **4 percentile ranks better** on Likelihood to Recommend
- ▲ **4 percentile ranks better** on Rate the Hospital



A 5-point increase in Rate the Hospital is associated with a **1% gain in net profit margin**

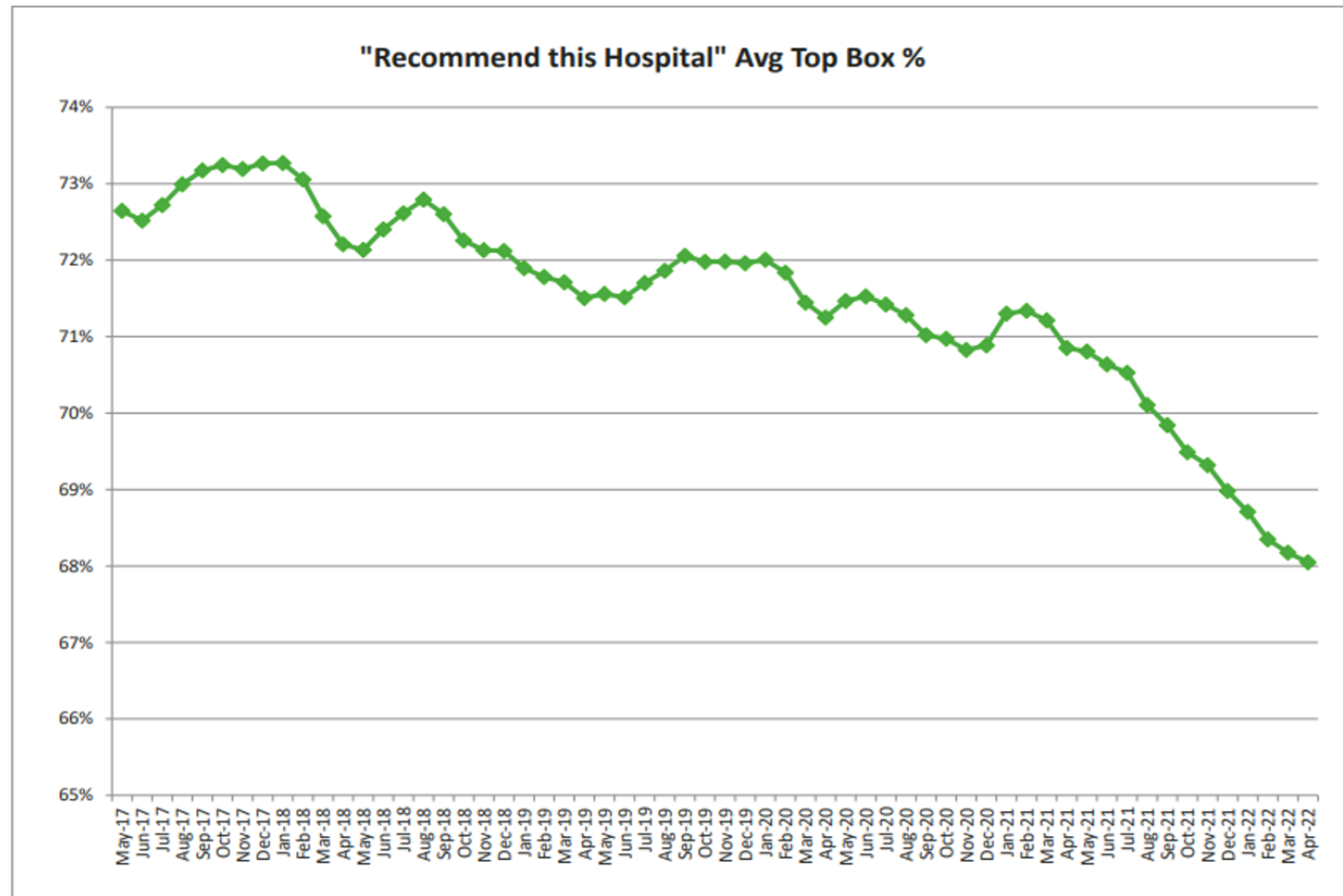


Inpatient 5 year trend (enterprise)



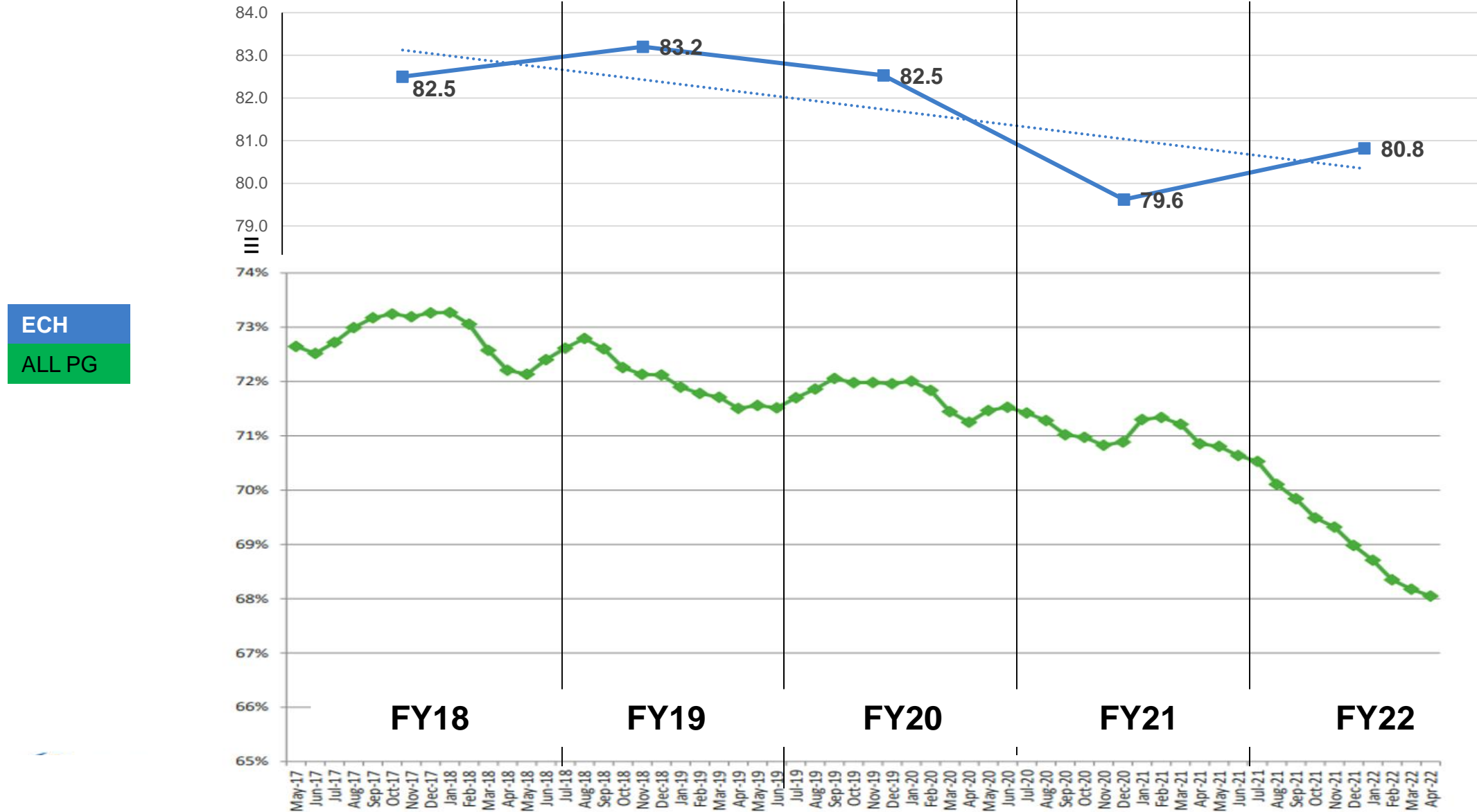
National HCAHPS 5 Year Trend

HCAHPS RECOMMEND HOSPITAL NATIONAL 5-YEAR TREND



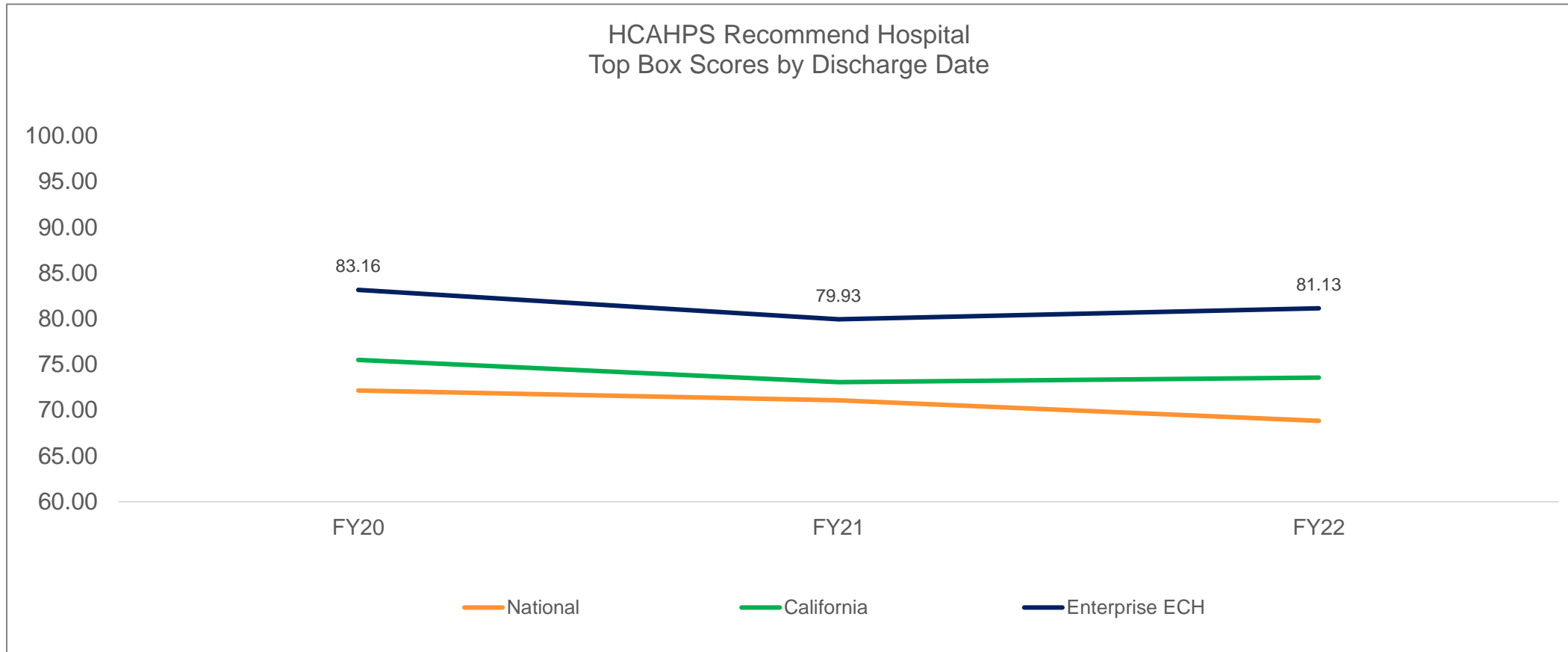
National HCAHPS 5 Year Trend

Inpatient (excluding MCH) ECH Compared to PG All Database



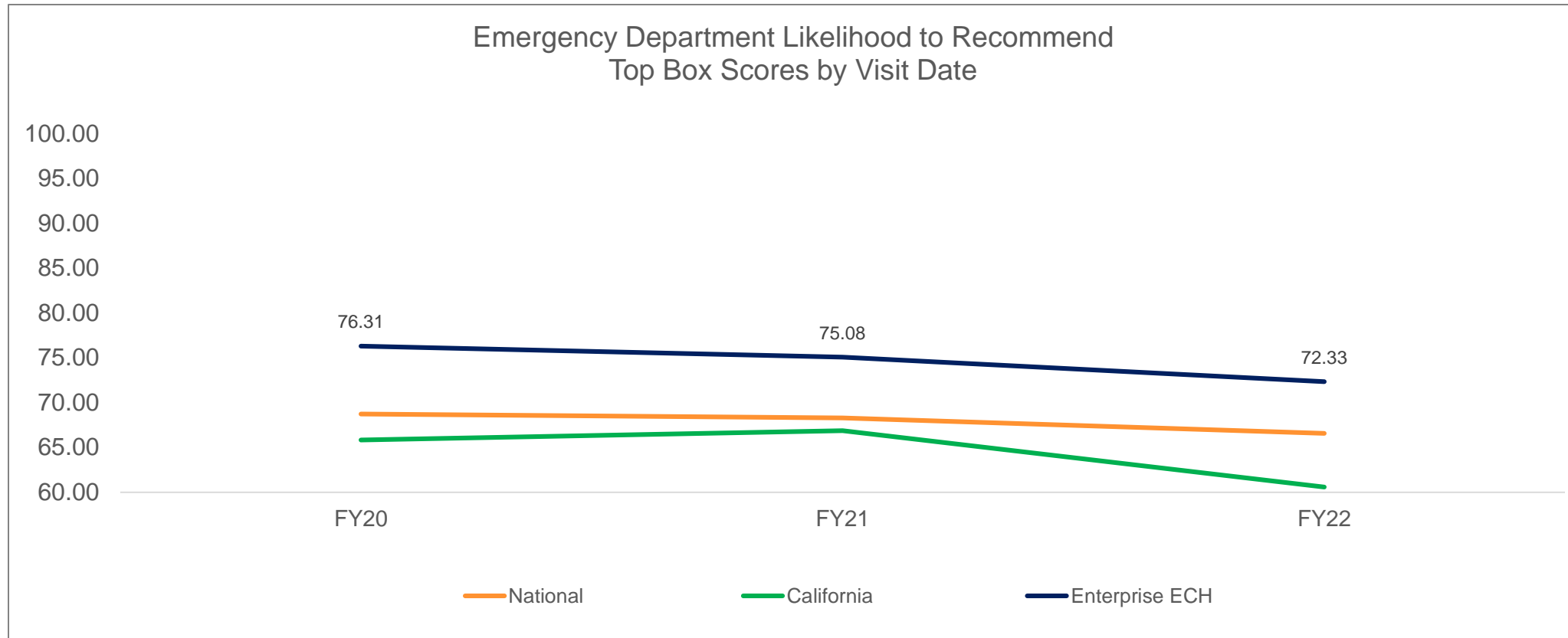
HCAHPS LTR (Likelihood to Recommend) Trends – 3 Year

In the past three (3) years, El Camino Health **outperformed California and national averages.**



Emergency Department LTR (Likelihood to Recommend) Trends – 3 Year

In the past three (3) year, El Camino Health **outperformed California and national averages.**



Loyalty – Likelihood to Recommend (LTR)

- Patients' LTR is more than an expression of satisfaction with their care
- This industry standard metric reflects the extent to which we have met our patients' needs – including their need for peace of mind resulting from compassionate and coordinated care and optimal clinical outcomes
- High ratings are correlated with patients' probability of returning for additional care and likelihood of recommending service to others – it reflects the extents to which we have earned a patients' **trust**
- In most of the industries studied, the percentage of customers who were enthusiastic enough to refer a friend or colleague—perhaps the **strongest sign of customer loyalty**—correlated directly with differences in growth rates among competitors
- If you're looking to gain market share and become the “provider of choice”, likelihood to recommend is typically the measure organizations use

<u>OVERALL ASSESSMENT (...continued)</u>	very poor	poor	fair	good	very good
	1	2	3	4	5
2. Your trust in El Camino Health to keep you safe during your care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
3. Likelihood of your recommending this hospital to others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
4. Overall rating of care given at hospital	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

19. Would you recommend this hospital to your friends and family?

Definitely no
 Probably no
 Probably yes
 Definitely yes

Summary of FY22

FY22 ECH LTR Year End Green ≥ Goal Red < Goal			LTR Response Distribution
Area	FY22 Target	% Top Box	% Very Good/ Good
Inpatient	79.7	80.8	96.2
MBU	82.0	81.3	96.1
ED	76.5	74.5	89.7
OP Surgery	86.1	86.4	97.3
OP Services	85.5	86.9	97.1
OP Oncology	88.8	89.0	98.2
*ECHMD - All	-	83.2	94.1
ECHMD - PCP	-	82.8	95.1
ECHMD - Specialty	-	87.5	96.7
ECHMD - Urgent Care	-	77.8	89.2

Partnering with Press Ganey on Goal Setting

Setting Realistic Goals

Press Ganey's Goal Setting Calculators

- Helps determine how much improvement you should expect based upon:
 - ❑ Your organization's current performance (top box and rank)
 - ❑ Amount of change/rates of improvement achieved by clients within the database: Past performance predicts future behavior

Press Ganey's Goal Setting Calculators

- Based on the amount of change other healthcare organizations saw from one year to the next, PG can provide 3 tiers of estimated targets
 - ❑ Threshold goal= Change seen by top 50% of clients within that decile
 - ❑ Target goal= change seen by top 30% of clients within that decile
 - ❑ Stretch goal= change seen by top 10% of clients within that decile

Based on starting percentile rank range:		
The top 50% of improvers saw this much change:	The top 30% of improvers saw this much change:	The top 10% of improvers saw this much change:
Threshold Goal	Target Goal	Stretch Goal

- The top 50, 30 and 10 are not annual numbers. Those are targets that are recommended based on the amount of improvement seen in the **Press Ganey database** from one year to the next. The 50, 30 and 10 are different tiers of performance, where 50% is the average amount of change clients in the national database saw, 30 is the top 30% of clients and 10% are the top 10% of clients.
- Historically the improvement targets put forth by Press Ganey reflect incremental increase in scores. This has changed in the past 2 years as patient experience scores have deteriorated during the pandemic. Goal recommendations from PG (for some organizations) now show a target of slowing the decline of the performance.

Rates of Change – the amount of improvement recommended based on the Press Ganey

HCAHPS Likelihood to Recommend Rates of Change 2020 to 2021

- Many organizations saw a decrease in performance over the pandemic, as shown by the negative amount of change below
- Setting a goal to sustain (0 improvement) may be challenging for many organizations

Starting Decile	Top 50% saw at least this much change	Top 30% saw at least this much change	Top 10% saw at least this much change
1-9	-0.34	2.30	6.11
10-19	-0.62	1.24	4.98
20-29	-0.98	0.54	3.71
30-39	-1.29	0.43	3.30
40-49	-1.46	0.14	2.36
50-59	-1.47	0.23	2.18
60-69	-1.63	-0.14	2.21
70-79	-1.47	-0.37	1.48
80-89	-1.65	-0.44	1.36
90-99	-1.16	-0.12	1.32

Statistical Significance

- Healthcare systems rarely use statistical significance to show level of improvement for LTR because there are so many nuances in healthcare and looking at the statistical significance of LTR does not explain the ‘why’
- PG has a goal setting calculator that does **not** take into account statistical significance, however, we are able to calculate the rate of improvement needed to be statistically significant
- Our methodology of creating goals is to partner with Press Ganey to use their goal calculator to calculate realistic improvement based on what health systems throughout the United States were able to achieve in addition to using their ‘rates of change’ recommendations
- A statistically significant improvement, year over year, would “often” be greater than 10% of improvers and would often not be achievable

Enterprise Level – 5 Year Z Test

- The chart below shows whether our LTR scores showed a statistically significant improvement (or decrease) from FY18 to FY22. The last column shows what the score would have needed to be in FY22 for their to be a statistically significant improvement over the five (5) year period.

Enterprise	FY18 LTR	FY22 LTR	Z Score	Significant Change ?	Approximate LTR needed for significant improvement at .01 level
Inpatient	82.8%	80.8%	-1.71	No	Approx. 85.0%
MBU	83.9%	81.3%	-1.18	No	Approx. 87.9%
ED	73.2%	74.5%	0.95	No	Approx, 75.9%
OAS	82.1%	86.4%	3.76	Yes, Increase	Significant Improvement
OP Services	83.1%	86.9%	4.20	Yes, Increase	Significant Improvement
OP Oncology	85.3%	89.0%	1.98	Yes, Increase	Significant Improvement

Significant at the .01 level
Significant at the .05 level
Not significant at either level

Service Area	FY22 Final	Top 50% Improvers	Top 30% Improvers	Top 10% Improvers	FY23 Target
Inpatient	80.8 (86% ile) (n=2200)	79.2 (82% ile)	80.4 (85% ile)	82.2 (89% ile)	81.0%
MCH	81.3 (86% ile) (n=640)	79.7 (83% ile)	80.9 (86% ile)	82.7 (90% ile)	81.5%
ED	74.5 (74% ile) (n=3697)	70.7 (78% ile)	72.2 (82% ile)	76.1 (91% ile)	75.0%
OAS	86.4 (59% ile) (N=2621)	86.4 (59% ile)	87.5 (67% ile)	89.4 (78% ile)	87.0%
Outpatient	86.9 (72% ile) (n=5466)	87.3 (74% ile)	87.9 (78% ile)	89.0 (85% ile)	87.3%
Oncology	89.0 (50% ile) (n=1768)	90.2 (69% ile)	91.0 (75% ile)	93.1 (89% ile)	90.2%
ECHMN (All)	83.2 (30% ile) (n=853, 9572)	83.4 (34% ile)	84.1 (38% ile)	84.5 (43% ile)	83.4%
ECHMN (PCP)	82.8 (27% ile) (n=325, 5,036)	84.1 (38%ile)	84.7 (42%ile)	85.5 (49%ile)	84.8%
ECHMN (Specialty)	87.5 (67% ile) (n=311, 3548)	87.0 (64%ile)	87.5 (68%ile)	88.9 (81%ile)	87.9%
ECHMN (Urgent Care)	77.8 (11% ile) (n=194, 976)	78.9 (15%ile)	80.7 (20%ile)	82.6 (28%ile)	77.8%

Questions



**EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO**

To: Quality Committee of the Board
From: Lyn Garrett, Senior Director Quality
Date: December 12, 2022
Subject: Patient Safety Indicator (PSI) Scores FY 2022 – Partial FY 2023 YTD

Purpose: To provide an update on the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators.

Summary:

1. **Situation:** The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events for all patients including following surgeries, procedures, and childbirth. The PSIs were developed by AHRQ after a comprehensive literature review, analysis of ICD-10-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; and include indicators for complications occurring in hospital that may represent patient safety events. These indicators also have area level analogs designed to detect patient safety events on a regional level. Additionally, PSIs are embedded in public reported scores and methodologies, like Hospital Compare, Leapfrog, & US News and World report.
4. **Assessment:** Each of the identified PSIs are first reviewed and validated by ECH Clinical Documentation Integrity and Coding professionals. If questions arise then clarifications from physicians are obtained. After cases are confirmed, identified cases are sent through the Medical Staff's Peer review process for trending by physician. The collaboration between physicians, clinical documentation specialists and coding team is imperative for an accurate reflection of these patient safety events.
5. **Performance:**
 - A. PSI-04 Death in Surgical Pts with treatable complications – 6 in FY 2023 YTD;
 - B. PSI-07 CLABSI – first case reported in the past four fiscal years;
 - C. PSI-12 Perioperative PE and DVT – the rate doubled for FY 2023. Review into the process of identification and management of DVTs is underway.
 - D. PSI-15 Unrecognized abdominopelvic accidental puncture or laceration – one case identified, although the trend is downward from previous year;
 - E. PSI-17 Birth Trauma Injury to Neonate – 6 occurrences;
 - F. PSI-18 and PSI-19 OB Vaginal trauma with & without instrument – both being addressed by Maternal Child Health Medical Leadership with case review and education on documentation of injury;

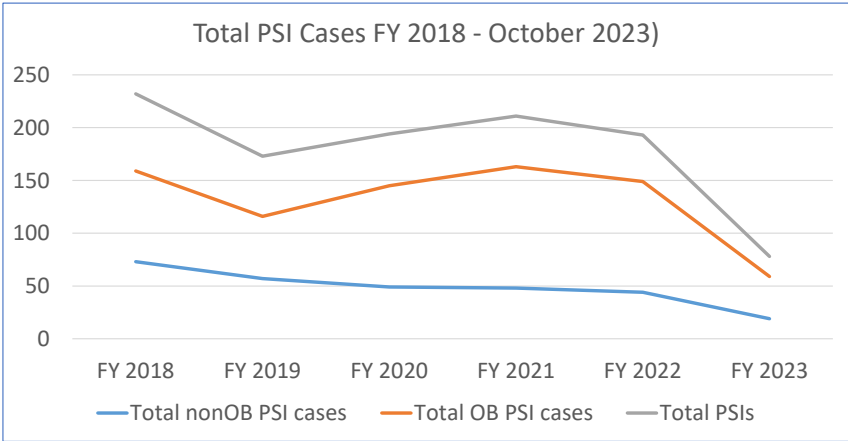
List of Attachments:

1. Patient Safety Indicator (PSI) Scores FY22 & FY23 YTD

Patient Safety Indicator Report (AHRQ) All Patients
FY 2022 - FY 2023 (JUL-OCT 2022)

Patient Safety Indicator	FY 2022			FY 2023 YTD (OCT)			Premier Mean* (Premier population benchmark) Rate/100
	Numerator	Denominator	Rate/1000	Numerator	Denominator	Rate/1000	
PSI-02 Death in Low Mortality DRGs	0	1,372	0.00	0	463	0.00	0.94
PSI-03 Pressure Ulcer	4	8,728	0.46	1	2,965	0.34	0.43
PSI-04 Death in Surgical Pts w Treatable Complications	12	130	92.31	6	30	200.00	129.51
PSI-05 Retained Surgical Item or Unretrieved Device Fragment	0	26,090	0.00	0	8,860	0.00	0.11
PSI-06 Iatrogenic Pneumothorax	1	13,634	0.07	0	4,671	0.00	0.12
PSI-07 Central Venous Catheter-Related Blood Stream Infection	0	13,540	0.00	1	4,579	0.22	0.07
PSI-08 In Hospital Fall with Hip Fracture	2	14,359	0.14	0	4,898	0.00	0.07
PSI-09 Perioperative Hemorrhage or Hematoma	7	3,668	1.91	1	1,150	0.87	1.85
PSI-10 Postoperative Acute Kidney Injury Requiring Dialysis	1	1,782	0.56	0	575	0.00	0.87
PSI-11 Postop Respiratory Failure	2	1,720	1.16	2	555	3.60	5.43
PSI-12 Perioperative PE or DVT	9	3,898	2.31	6	1,235	4.86	2.59
PSI-13 Postop Sepsis	1	1,764	0.57	1	566	1.77	3.87
PSI-14 Postop Wound Dehiscence	1	1,480	0.68	0	479	0.00	0.80
PSI-15 Unrecognized Abdominopelvic Accidental Puncture or Laceration	4	3,322	1.20	1	1,078	0.93	0.77
PSI-17 Birth Trauma Injury to Neonate	16	5,065	3.16	9	1,696	5.31	3.68
PSI-18 OB Trauma Vaginal Delivery with Instrument	48	281	170.82	15	80	187.50	105.98
PSI-19 OB Trauma Vaginal Delivery without Instrument	85	3,170	26.81	35	1,065	32.86	15.02
Total non-OB PSIs	44			19			
TOTAL PSIs	193			78			

Green = better than Premier Mean



**EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO**

To: Board Quality Committee
From: Jessica Harkey, Manager, Sepsis Quality
Daniel Shin, MD, Director, Medical Quality
Date: December 12, 2022
Subject: Sepsis Mortality Index

Purpose: Review the current state of sepsis care at El Camino Health and performance improvement initiatives to reduce the Sepsis Mortality Index

Recommendation: No motion required

Authority: The Board Quality Committee is responsible for oversight of quality status and quality improvement activities.

Situation: The Sepsis Mortality Index had increased over FY21, which was a nationally recognized shift even among the very top health system performers. ECH has seen an overall improvement in the FY22 Sepsis Mortality Index, and the FY23 target has been adjusted accordingly.

Background: Sepsis continues to be a significant driver of overall mortality. While mortality rates are over 40% for patients admitted to a hospital with septic shock, for patients identified earlier mortality rates decrease to 17% based on national data. (El Camino Health mortality rate for all sepsis patients is currently 10.88% which is considered quite low) A deep dive analysis of El Camino Health sepsis experience is included in the attachments below.

Assessment: Based on FY22 data analysis and clinician feedback here is a summary of the findings for current state:

- Overall higher sepsis bundle compliance in the survival group, particularly interventions shown to benefit outcomes (time to antimicrobial therapy, fluid resuscitation and prevention of progression to shock).
- High percentage of DNR on admission and advanced age & co-morbid conditions (oncology patients).
- Significant decrease to zero in GIP care transitions and opportunities to discharge to hospice when converted to comfort care code status (hospice facility capacity, staffing, family/caregiver ability to care for patient at home).
- Overall increase in Palliative Care consults, particularly patients who are re-admitted within 30 days.
- Re-admissions carry a higher mortality rate.

The FY23 sepsis mortality index improvement plan has two major components, which are, improve clinical care and focus on transitions of care and re-admissions:

Improve Clinical Care

- Increase 1-3 hr. bundle compliance – especially ABX within 1 hr., and target fluid bolus

Sepsis Mortality Index
December 12, 2022

- ED has restructured their sepsis alert and treatment process, which has shown significant success, ongoing PDSA cycle to continue improvement.
- Increase overall SEP-1 bundle compliance –composite measure
 - Provide provider level data on bundle compliance by specialty and for OPPE
 - Most failure cases are based on documentation improvement opportunities as opposed to clinical care.
 - Failed sepsis cases are sent to medical staff leadership
- Improve EHR tools
 - Existing Epic solutions not currently meeting the needs of the program and frontline caregivers, under thorough evaluation vs 3rd party applications

Improve transitions of Care and Re-admission rates

- Sepsis Navigator position to focus on improved communication w/patient, family, care coordination and post-acute providers (SNF and home health).
- Provide education (initial and ongoing) to post-acute partners on sepsis identification, patient risk for re-admission, and communication tools. Focus on early identification and SNF provider/PCP notification.
- Post-discharge follow-up phone calls, to home and/or SNF teams.

Finally, the Sepsis Mortality Index target was adjusted to better reflect the reality of our own experience and that of the top performers across the United States. This adjustment follows the SMART approach to goal setting: Specific, Measurable, Achievable, Relevant, and Time-Bound.

List of Attachments:

1. Sepsis Mortality Index and Performance Analysis
2. IHI Forum Poster Submission



FY 22 Sepsis Mortality Review

Quality Committee

*Prepared by Jessica Harkey, Manager, Sepsis Quality and
Yuliya Koskov, Quality Data Analyst- Sepsis Program
December 12, 2022*

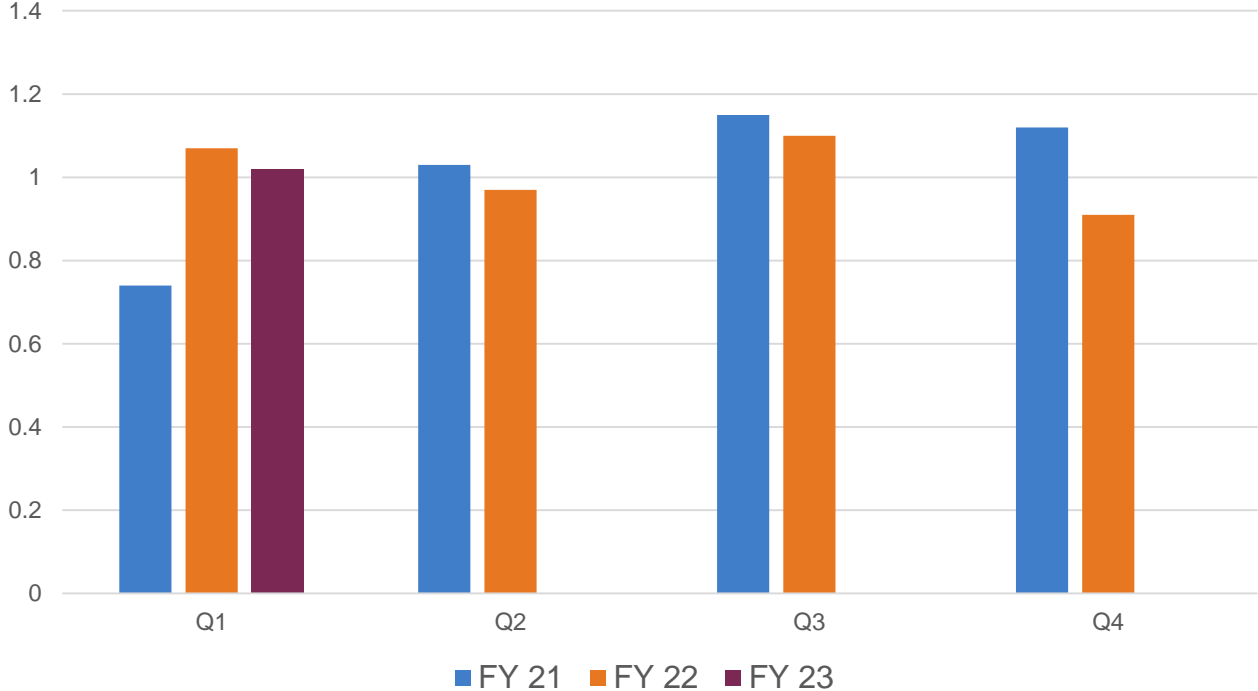
September 2022 (unless otherwise specified)

November, 2022

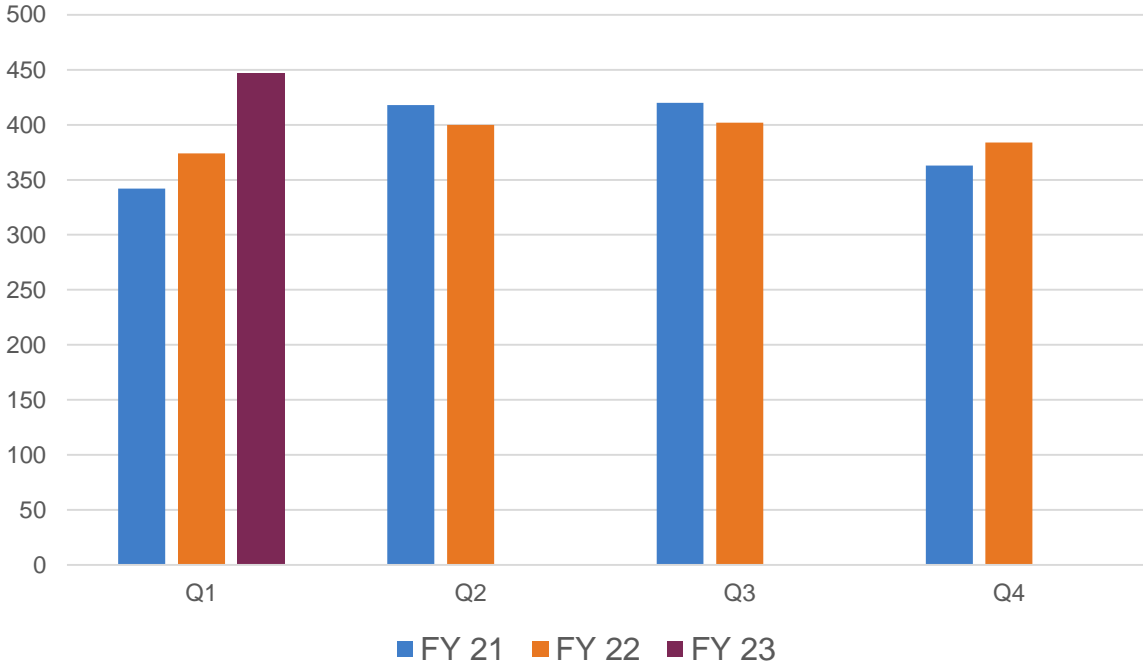
	FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend <i>(showing at least the last 24 months of available data)</i>	FYTD or Rolling 12 Month Average
	Latest month	FYTD				
Sepsis Mortality Index, based on ICD-10 codes <i>(Observed over Expected)</i> Latest data month: Sep, 22	0.89 (9.40%/10.54%)	1.02 (11.19%/10.98%)	1.03	0.98		

Historical Perspective

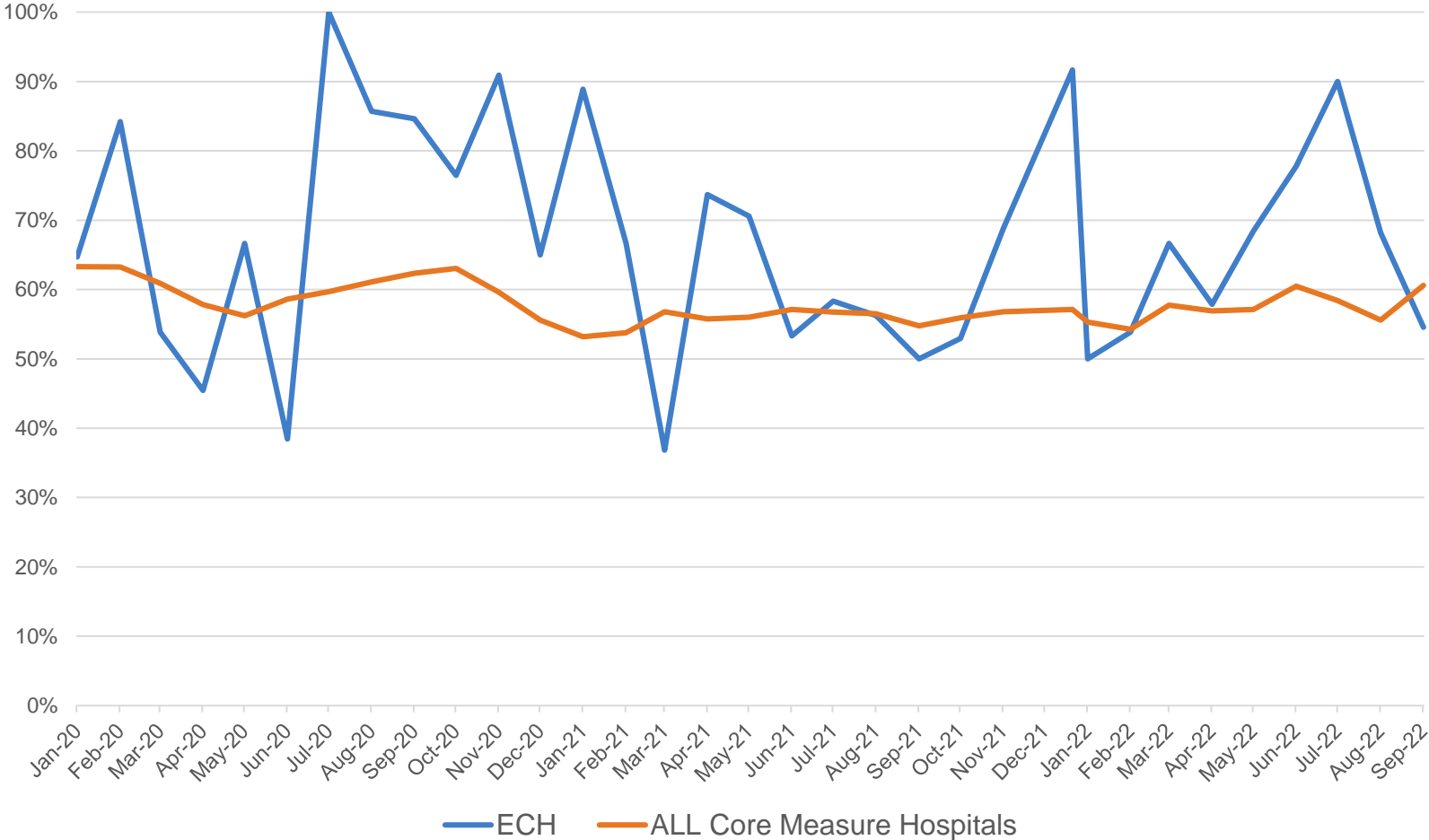
Sepsis Mortality O/E



Sepsis Volumes



SEP-1 Core Measure




Survival to Discharge Group

(refer to definitions in chart)

Key to Sepsis Survival is improved compliance with the sepsis bundle elements:

Note on average *higher* rate of:

- Early antimicrobial therapy
- Fluid bolus
- Achieved perfusion target (MAP)
- Overall bundle compliance

Sepsis Program All Patients (except Mortality)			
 El Camino Health Quality, Safety and Risk	ECH Monthly SEP-1 (All Patients) August 2022	ECH Compliance Rate September 2022	ALOS September 2022
	56% (15/22) Sample size 24	62% (n=31/50)	6.04

Sepsis Bundle Metrics												
	September 2022	August 2022	July 2022	June 2022	May 2022	April 2022	March 2022	February 2022	January 2022	December 2021	November 2021	October 2021
Lactate Drawn w/in 1 hr of TOP-Target 75%	94%	93%	94%	100%	96%	98%	98%	98%	98%	98%	94%	92%
Abx given within 1 hour of TOP- Target 75%	90%	86%	80%	79%	84%	76%	80%	89%	85%	72%	72%	84%
Blood cultures drawn prior to abx admin-Target 75%	84%	90%	92%	94%	94%	95%	93%	91%	100%	84%	87%	88%
Appropriate selection based on suspected source (1)	100%	100%	98%	100%	100%	96%	98%	100%	100%	98%	98%	100%
Was 30mL/kg cryst Fluid Given w/in 3 hours (2) - Target 90%	72%	82%	77%	88%	85%	77%	78%	71%	71%	74%	62%	64%
Repeat Lacate Done w/in 6 hrs (3) - Target 90%	94%	96%	94%	100%	100%	96%	94%	97%	97%	97%	98%	100%
Vasopressor administered for shock (4)	88%	100%	90%	86%	100%	63%	75%	75%	86%	100%	33%	57%
Norepi first choice (5)	100%	100%	100%	100%	100%	83%	100%	100%	100%	100%	100%	100%
MAP>=65 at 6 hours from TOP-Target 90%	94%	98%	84%	83%	100%	83%	98%	96%	89%	94%	92%	92%
Shock Re-assessment (6) - Target 75%	95%	85%	87%	92%	95%	76%	79%	94%	94%	88%	80%	74%
Sepsis Alert Rate	62%	76%	76%	62%	69%	47%	40%	49%	49%	16%	21%	18%
ECH Bundle Comp Rate	62%	69%	62%	70%	73%	55%	59%	70%	77%	58%	55%	53%

Order Set Used September 2022	#1 Infection September 2022
42% (n=21/50)	Lungs 12 Lungs/Urine 2 Urine 14 Urine/SSTI 1
TOP admitting units September 2022	
MV 2C MEDICAL	6
MV 3AC CCU	7
MV 3AP PCU	8
MV 3C TELEMET..	7

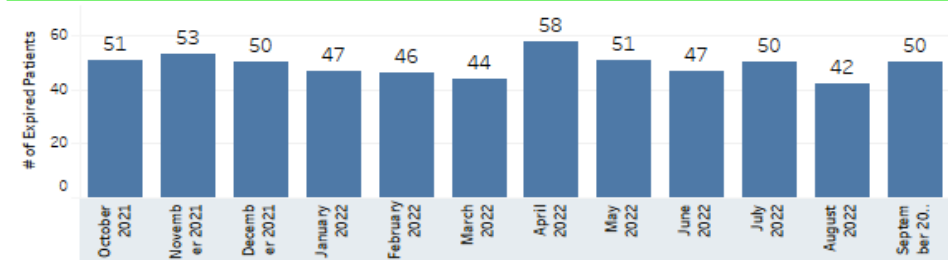
**Beginning with January 2021 data, the following changes were made:

- All COVID cases excluded (active, rule out, suspected)
- Abstraction method for 30 mL/kg fluid bolus administration time using criteria of 2 documented hypotensive readings (SBP<90 or MAP<65) within 3 hours of each other (do not need to be consecutive) OR initial lactate \geq 4 mmol/L.

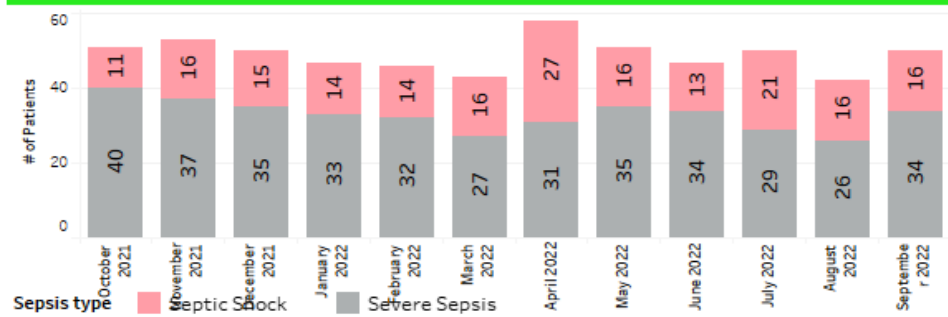
Data definition:

- Patients age >18 years, presenting in the Emergency Dept or In-patient unit with Severe Sepsis/Septic Shock (Suspected or known infection, 2+SIRS, 1 new organ dysfunction). Retrospective or concurrent chart reviews based on admitting diagnosis, Sepsis Alert, QRR, EHR surveillance, iCare reporting. (not based on ICD-10 discharge coding).
- Hypotension: SBP<90 or MAP<65
- (1) using empiric selection guides posted by pharmacy and attachment in sepsis policy.
- (2) denominator=patients with initial LA \geq 4 OR hypotension
- (3) denominator=patients with initial LA \geq 2
- (4) patients with persistent hypotension after adequate fluid resuscitation
- (5) norepinephrine used as first line agent when vasopressor used
- (6) denominator=patients with initial LA \geq 4 regardless of BP, OR requiring vasopressor support ..

Monthly Sepsis All Patients (Except Mortality) Rolling 12 months



Sepsis Type - All Patients (except Mortality)



**Early Identification and appropriate management in the initial hours after the development of sepsis improve outcomes (Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock 2021)*


**Compliance with SEP-1 was associated with lower 30-day mortality. Rendering SEP-1 compliant care may reduce the incidence of avoidable deaths (Townsend, et al, j.chest. 2021.072167)*

Mortality Group (observed, not risk adjusted)

Note *higher* rate of:

- Shock
- Early antimicrobial therapy
- Fluid bolus
- Achieved perfusion target (MAP)
- Overall bundle compliance

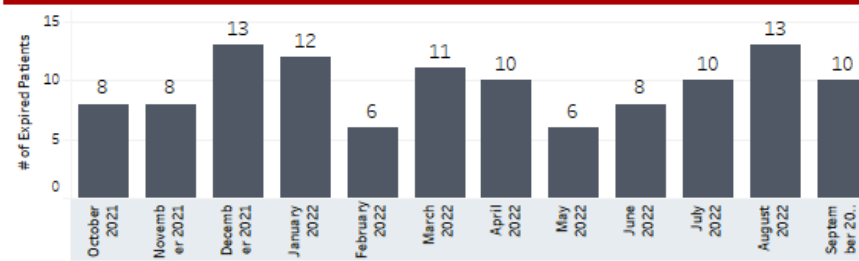
Note on average *lower* rate of:

Sepsis Program- Mortality Report			
 El Camino Health Quality, Safety and Risk	ECH Monthly Mortality Index FYTD September 2022	ECH Compliance Rate September 2022	ALOS September 2022
	1.02 (11.19%/10.98%) Target 0.98	70% (n=7/10)	12.36

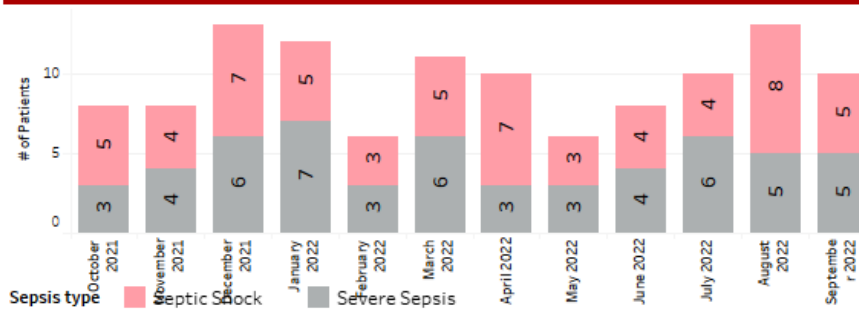
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Appropriate selection based on suspected source (1)	100%	100%	100%	100%	100%	100%	82%	100%	100%	100%	100%	88%
Was 30mL/kg cryst Fluid Given w/in 3 hours (2) - Target 90%	83%	63%	40%	100%	50%	63%	57%	100%	83%	63%	40%	86%
Repeat Lacate Done w/in 6 hrs (3) - Target 90%	86%	100%	100%	100%	100%	100%	100%	100%	100%	92%	80%	100%
Vasopressor administered for shock (4)	100%	80%	100%	100%	100%	100%	86%	100%	100%	100%	100%	60%
Norepi first choice (5)	100%	80%	100%	100%	100%	100%	83%	100%	100%	100%	100%	100%
MAP>=65 at 6 hours from TOP-Target 90%	90%	77%	70%	100%	83%	70%	64%	100%	92%	85%	88%	50%
Shock Re-assessment (6) - Target 75%	100%	75%	100%	80%	100%	57%	71%	67%	100%	71%	80%	71%
Observed mortality(not risk adjusted)	100%	100%	90%	88%	100%	90%	100%	100%	100%	100%	100%	100%
Sepsis Alert Rate	90%	85%	60%	63%	67%	40%	55%	33%	50%	38%	75%	0%
ECH Bundle Comp Rate	70%	38%	50%	75%	50%	40%	45%	50%	83%	54%	50%	25%

Order Set Used September 2022	Admitting Units September 2022
70% (n=7/10)	LG L05 MED SURG ONC 1
#1 Infection September 2022	LG L06 ICU 2
Lungs 5	MV 3AC CCU 5
Unknown 1	MV 3AP PCU 1
Urine 4	MV 3C TELEMETRY/STR.. 1

Monthly Sepsis Mortality October 2021-September 2022



Mortality Patients by Sepsis Type



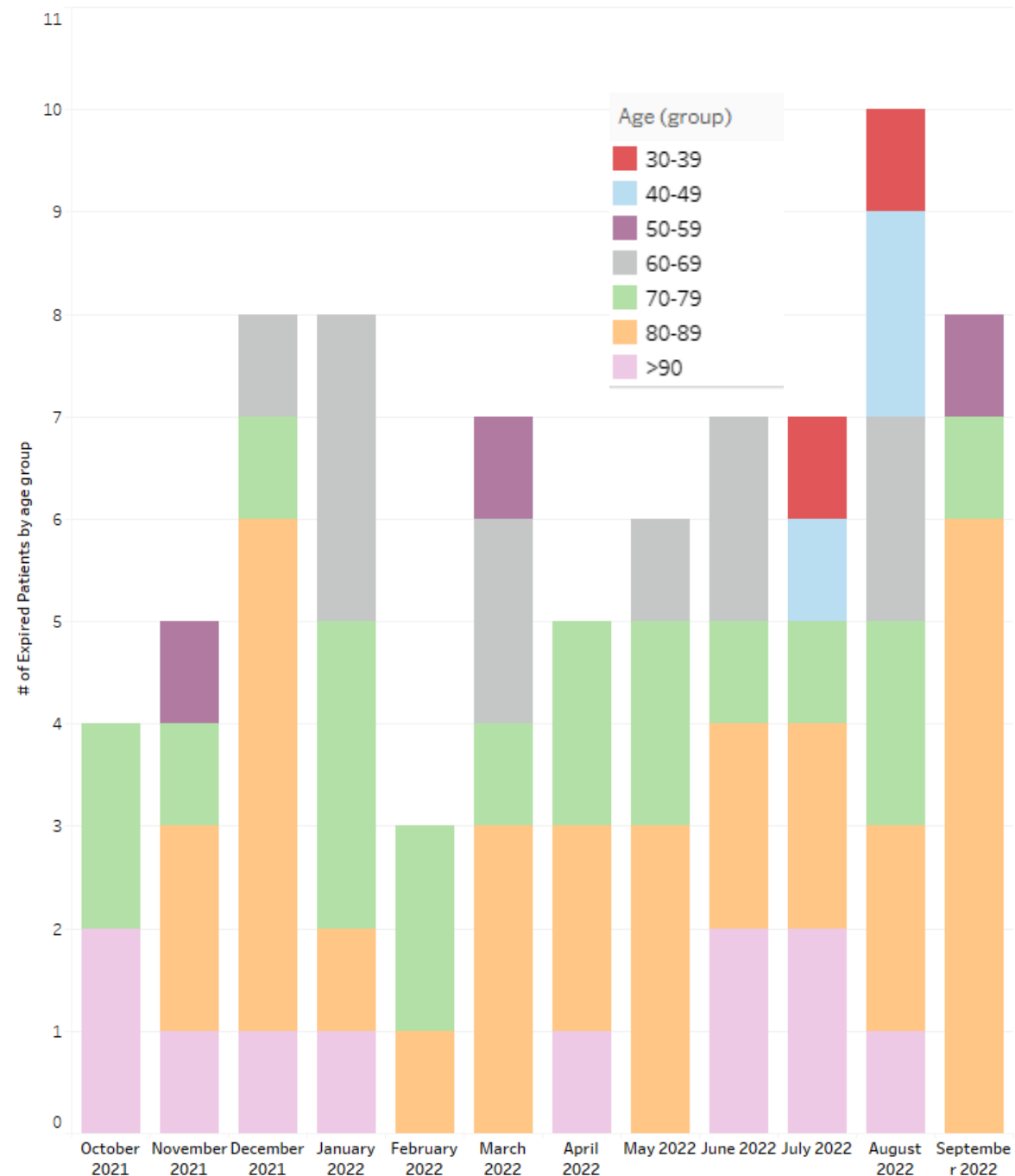
****Beginning with January 2021 data, the following changes were made:**

- All COVID cases excluded (active, rule out, suspected)
- Abstraction method for 30 mL/kg fluid bolus administration time using criteria of 2 documented hypotensive readings (SBP<90 or MAP<65) within 3 hours of each other (do not need to be consecutive) OR initial lactate \geq 4 mmol/L.

Data definition:

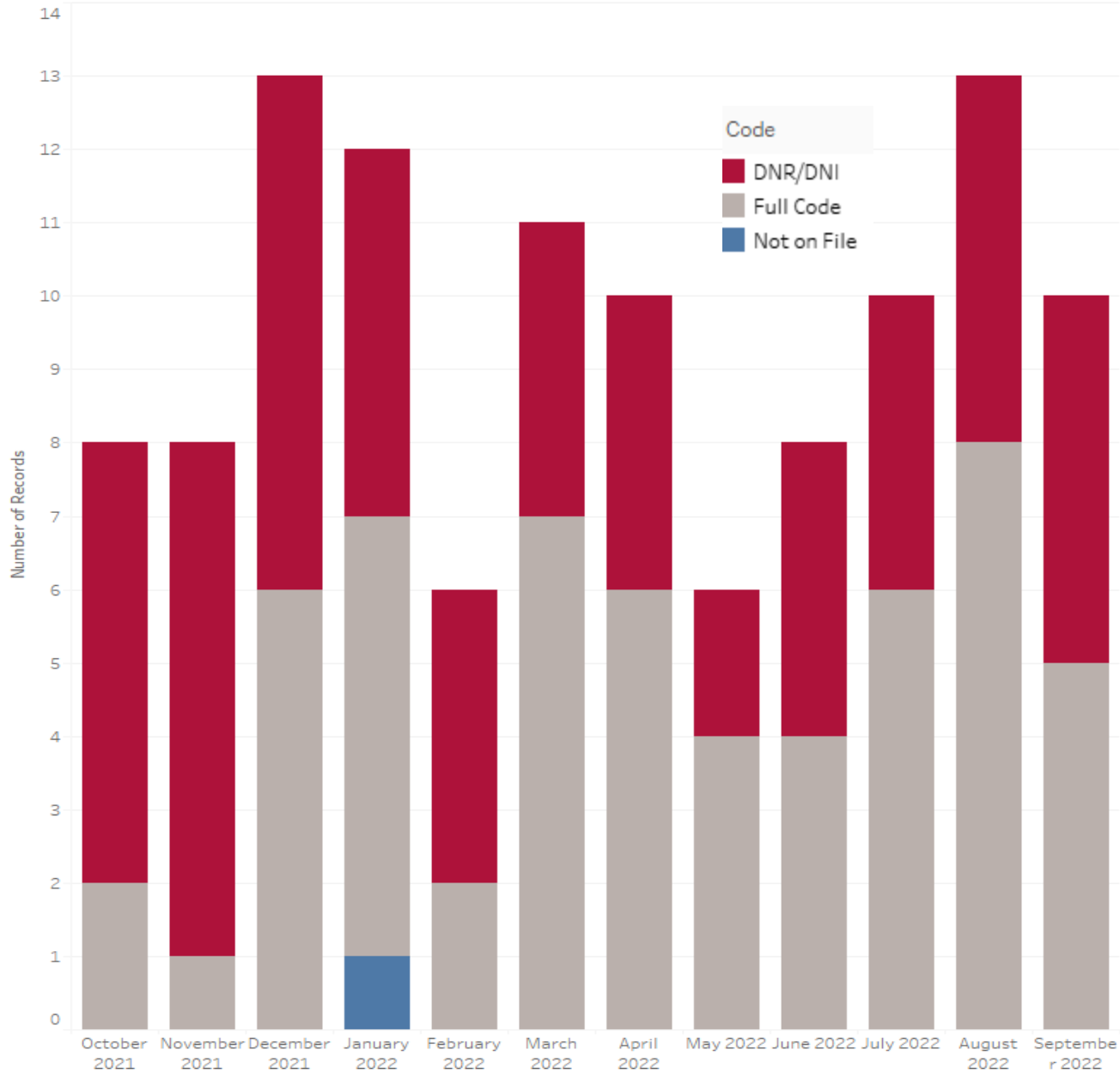
- Patients age >18 years, presenting in the Emergency Dept or In-patient unit with Severe Sepsis/Septic Shock (Suspected or known infection, 2+SIRS, 1 new organ dysfunction). Retrospective or concurrent chart reviews based on admitting diagnosis, Sepsis Alert, QRR, EHR surveillance, iCare reporting. (not based on ICD-10 discharge coding).
- Hypotension: SBP<90 or MAP<65
- (1) using empiric selection guides posted by pharmacy and attachment in sepsis policy.
- (2) denominator=patients with initial LA \geq 4 OR hypotension
- (3) denominator=patients with initial LA>2
- (4) patients with persistent hypotension after adequate fluid resuscitation
- (5) norepinephrine used as first line agent when vasopressor used
- (6) denominator=patients with initial LA \geq 4 regardless of BP, OR requiring vasopressor support ..

Sepsis Program-Mortality Patients by age group

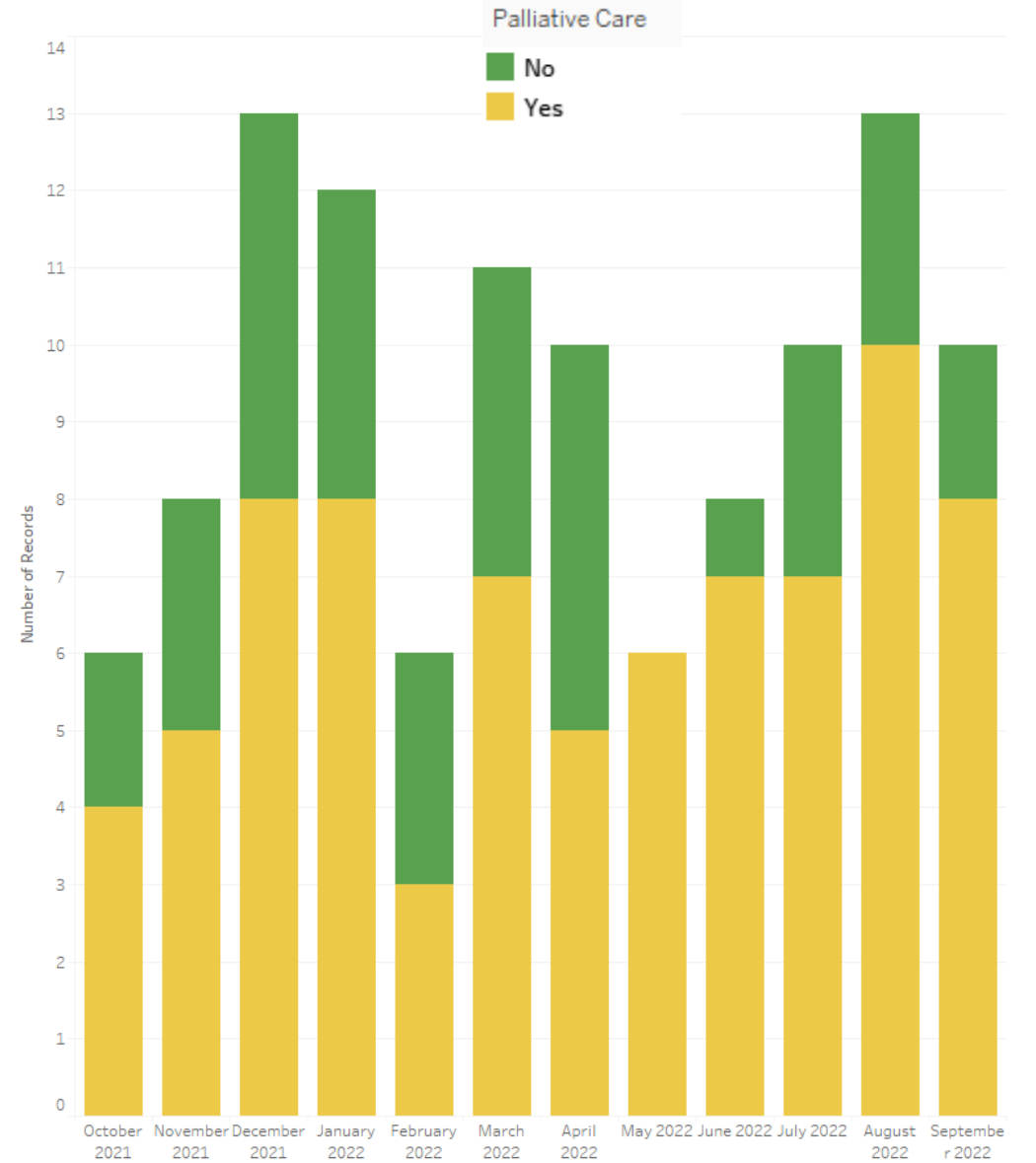


Month, Year of Admi..	30-39	40-49	50-59	60-69	70-79	80-89	>90	Grand To..
October 2021	0	0	0	0	2	0	2	4
November 2021	0	0	1	0	1	2	1	5
December 2021	0	0	0	1	1	5	1	8
January 2022	0	0	0	3	3	1	1	8
February 2022	0	0	0	0	2	1	0	3
March 2022	0	0	1	2	1	3	0	7
April 2022	0	0	0	1	2	2	1	5
May 2022	0	0	0	1	2	3	0	6
June 2022	0	0	0	2	1	2	2	7
July 2022	1	1	0	0	1	2	2	7
August 2022	1	2	0	2	2	2	1	10
September 2022	0	0	1	1	1	6	0	8
Grand Total	2	3	3	11	19	29	11	78

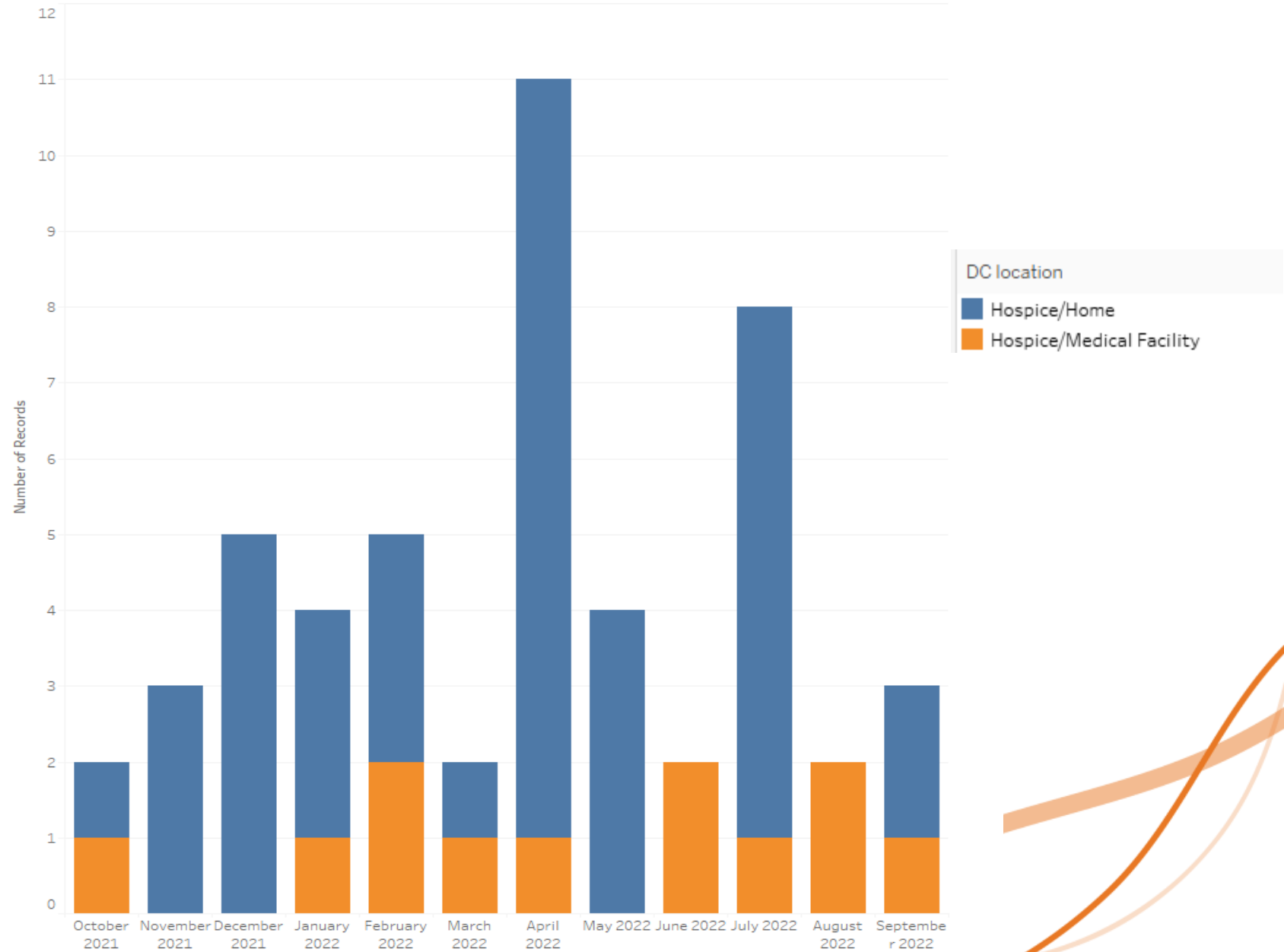
Sepsis Program-Mortality cases by Code Status at Admission



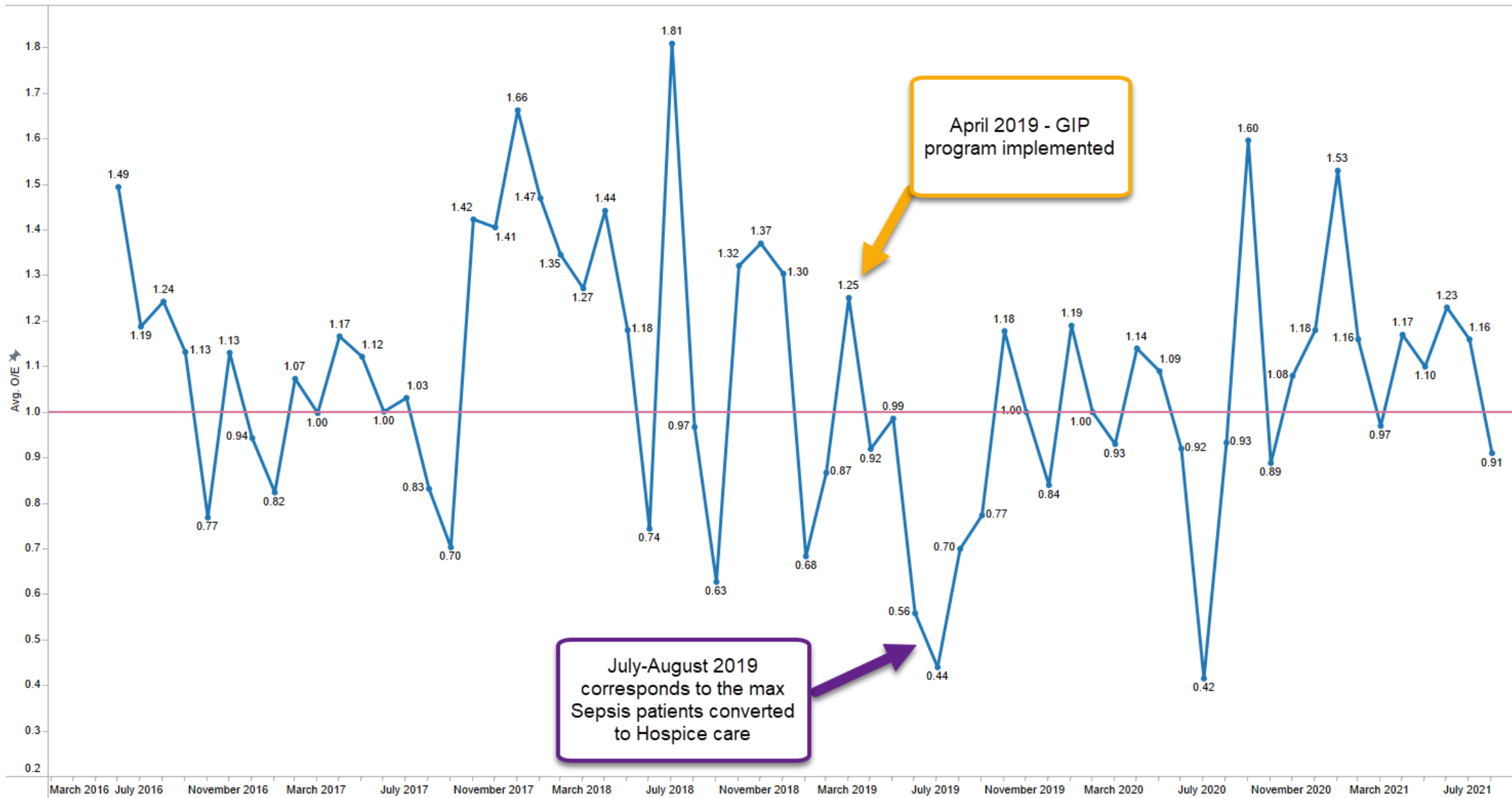
Expired Patients-Palliative Care only



Sepsis Program: Discharge Disposition: Hospice

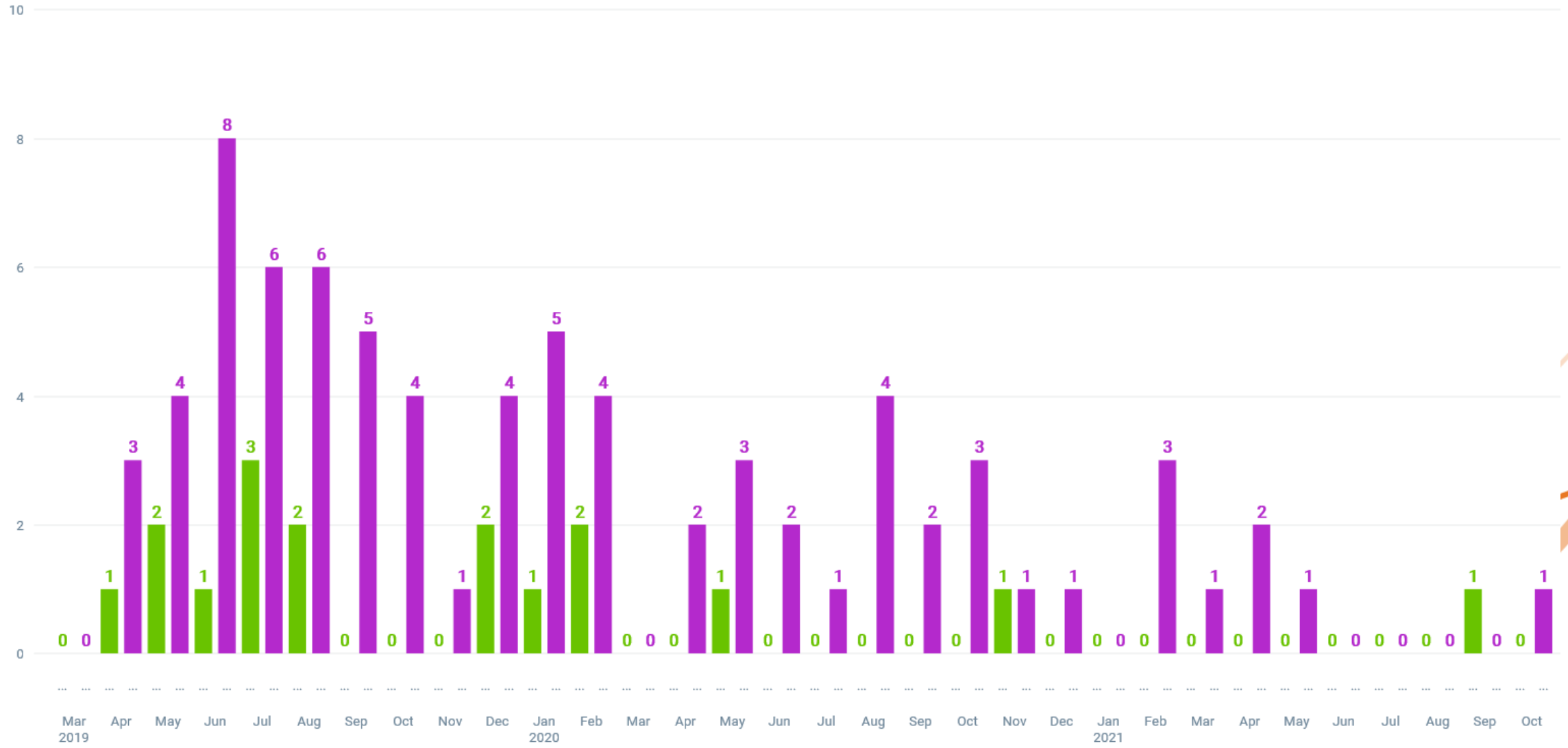


Sepsis Mortality Index (lower is better)



Patients converted to Hospice (green bars - Sepsis)

Between 3/1/2019 and 10/31/2021 by month



Months

Overall Summary/Findings from FY22 data analysis and feedback from clinicians:

- Overall higher sepsis bundle compliance in the survival group, particularly interventions shown to benefit outcomes (time to antimicrobial therapy, fluid resuscitation and prevention of progression to shock).
- High percentage of DNR on admission and advanced age & co-morbid conditions (oncology patients).
- Significant decrease to zero in GIP care transitions and opportunities to discharge to hospice when converted to comfort care code status (hospice facility capacity, staffing, family/caregiver ability to care for patient at home).
- Overall increase in Palliative Care consults.

Sepsis Program Initiatives

- NEW Sepsis Navigator position in place April 2022
 - In-house rounding, post-discharge phone calls, post-acute partnership
- Revised ED Sepsis Alert, screening & treatment initiation workflow
 - Sept 2021 resulted in monthly increase in bundle success and lower mortality
- Provider level scorecards
- Ongoing collaboration between Sepsis team and CDI, case reviews and provider education
- Sepsis transitions of care/re-admissions work groups in place
- AIMS study enrollment (SCCM) with focus on implementation science, evaluating outcomes of 1 vs 3 hour bundle

Patients with **sepsis** have increased survival and faster treatment in the ED when **nurses drive screening** and treatment **alerts**.

Sepsis Performance Improvement in the Emergency Department: Screening, Identification and Alert Re-design.

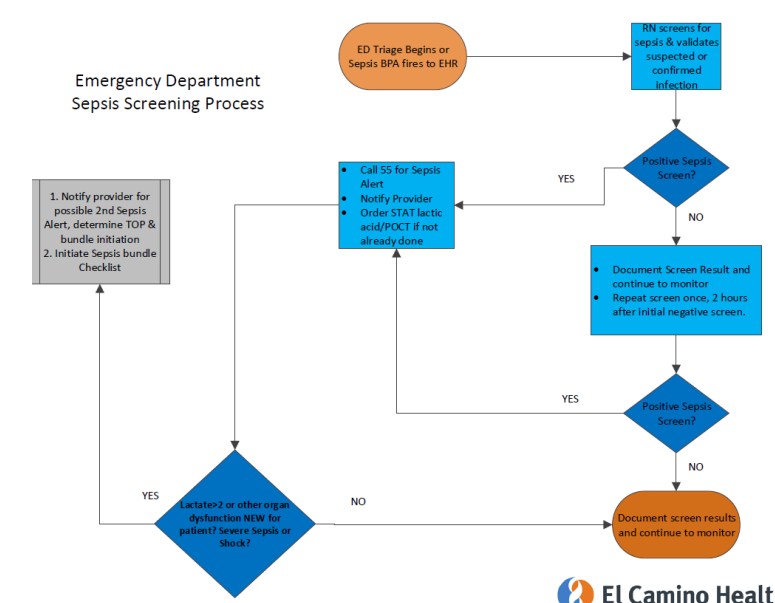
Background: Existing EHR screening tools for sepsis were lacking relevant information and workflows for activating a “sepsis alert” were unclear. For monthly data analysis, a sampled population of severe sepsis/septic shock patients revealed: low alert rates, inconsistent screening results, and sepsis treatment bundle performance below set target(s).

Project Aim: Our goal was to re-design the entire ED workflow to re-define a positive sepsis screen, and qualifying criteria for alert activation to improve overall bundle compliance.

Project Strategy: A sub-committee was formed including frontline and leadership representatives for nursing, medical staff, laboratory, pharmacy, and clinical informatics. Baseline data was reviewed, staff were interviewed and observed to identify potential barriers and variations in care processes.

Changes Made:

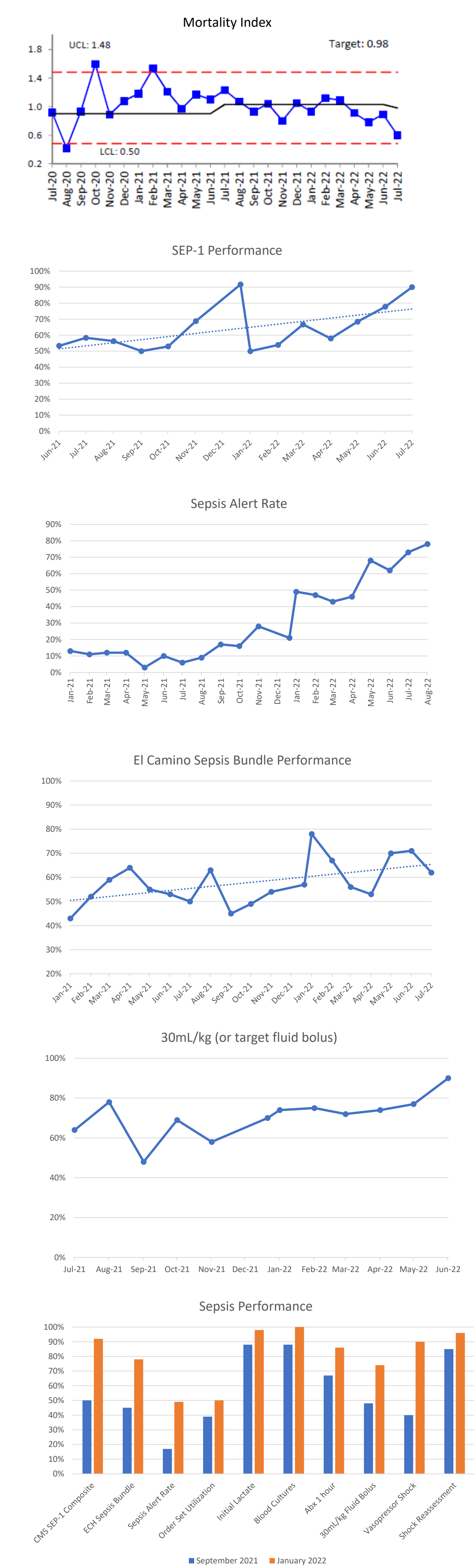
- EHR screening tool revision which broadened criteria and captured more patients. Nursing EHR documentation tools revised to capture clinical events related to sepsis.
- The sepsis alert trigger and expected responses were clarified, ultimately shifting the focus from a treatment alert to expedite nurse-driven work-up, identification and early bundle initiation.



Results: We observed month-over-month improvements in several metrics including mortality.

Next Steps: Evaluate outcomes and process measures comparing the alert vs no alert groups, in addition to rates of progression to shock and critical care admissions. Develop sustainability plan in times of staffing/throughput challenges.

OUTCOMES



Contacts:
 Jessica Harkey, MSN, RN, ACCNS-AG- Manager, Sepsis Quality
 Jessica_Harkey@elcaminohealth.org
 Laura Cook, MD, ED Medical Director
 Laura_Cook@elcaminohealth.org
 Jumana Baluom, MSN, RN, CEN, TCRN-ED Clinical Manager
 Jumana_Baluom@elcaminohealth.org



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SCAN ME

Terhilda Garrido

SUMMARY

A seasoned leader focused on leveraging analytics and digital innovation in a transformation to 'smarter' healthcare.

With over 29 years at Kaiser Permanente, an \$80 BB integrated health care delivery system, developed a deep understanding of healthcare. As VP, Health IT Transformation & Analytics, was responsible for realizing strategic value and maximizing opportunities using HIT and advanced analytics. Awarded KPLA 'Pathmaker Award'. Rounded experience since retirement by working in/with early stage organizations. Governance experience with two boards Skilled in working with senior management, operations leaders, researchers and MDs; and managing complex decision processes while integrating a range of stakeholder interests. Excel in innovating, developing vision and the tactical planning to achieve. A reputation for strategic planning and execution. Fluent Spanish.

VALUE PROPOSITION

Patient-Centered Care Strategy & Innovation

- As VP, Health IT Transformation & Analytics at KP, led team responsible for realizing value and identifying/maximizing opportunities with KP IT. Led KP business case for \$4 Billion investment in the electronics health record.
- Championed, piloted and evaluated kp.org personal health record which transformed primary care at KP. 51% of all primary care MD contacts are now virtual laying the foundation for telemedicine.
- Developed KP 'Blue Sky Vision' as framework for EHR investment.
- Assessed / advised on early stage healthcare organizations and proposals for GE Ventures, RHIA Ventures and OPTions.

Analytics Leadership

- Led organizational assessment of analytic tools and the formation of the Analytics Council representing 2000 BI coders and data scientists
- Built an analytic department (0 to 40 FTEs) that developed population health tools, predictive models for risk, NLP tools to assess free text in the medical record, assessed AI solutions such as IBM Watson and created hundreds of BI reports.
- Assessed / advised early stage organizations leveraging analytic tools in their operations for GE Ventures and RHIA Ventures portfolio.

Healthcare / Equity Range of Experience

- Worked with all members of the clinical leadership at a national, regional and local level across inpatient, outpatient and virtual continuum to solve operational issues.
- Worked in large corporate environment (\$88BB organization) and with small startups. Assessed/advised on early stage healthcare organizations and proposals for GE Ventures, RHIA Ventures and OPTions.
- Led early work on Medicare Risk-sharing products and Medicare 'Meaningful Use'

BOARD EXPERIENCE

Heluna Health, Industry, CA.

2022- Current

National organization that empowers healthcare organizations and researchers to improve the health and well-being of their communities with \$700M in revenues annually. Develops effective partnerships for population health and innovation. The organization builds evidence-based programs, provides fiscal support, and develops custom solutions.

Member of the Board of Directors, Audit committee

CareMessage, San Francisco, CA.

2020- Current

Start-up that partners with Medicaid/FQHC organizations to bring mobile technologies to the underserved and uses their platform to communicate critical health information to their patient populations.

Member of the Board of Directors, Audit committee

Possible Health, Nepal.

2016 - 2020

NGO providing innovative, affordable healthcare in Nepal that leverages technology and the accountable care model.

Member of the Board of Directors

2016-2018

Chair, Board of Directors

Kaiser Foundation Health Plan/Hospitals, Oakland, CA.

Presented to \$3Billion business case to Board of Kaiser Foundation Health Plan.

Presented investment cases to RHIA Ventures Board, Member of Latino Corporate Directors Association. Served on Advisory Board to SAS- Intl, Alumni Society, and InformedDNA. 'Break into the Boardroom' program sponsored by Oxeon/Deerfield.

PROFESSIONAL EXPERIENCE

Rhia Ventures, San Francisco, CA

2018- 2020

Social impact investment firm in women's health. A startup making thesis-driven investment in seed through Series C companies.

Strategic Director, Impact and Digital Access / Consultant

GE Ventures, Menlo Park, CA

2017-2018

Venture Capital group provides access to a global network of GE expertise and resources. Partners and invests in innovative ideas and companies in Health IT, big data analytics and health care improvement.

Executive in Residence

Kaiser Permanente, Oakland, CA

1983-1986 and 1989-2016

Nation's largest managed care org - non-profit insurance company, non-profit hospital system and medical group partnerships. This \$60B/year organization provides for 10M members in CA & nation with 38 hospitals and 17,000 physician partners.

Vice President, HIT Transformation / Analytics – Program Office 2005-2016

- Formed and grew an advanced analytics team focused on self-service business intelligence and deep analytic and statistical work including predictive analytics and NLP.
- Promoted KP's HIT and Analytic leadership role with nat'l and international speaking appearances. Supported KP policy efforts in Washington, DC.
- Championed data extraction capabilities and provided clinical leaders with new insights from new data. Led work with IT and Research on an Analytics for Care Transformation strategy.
- Leading 'Meaningful Use' efforts in Kaiser for CMS/ONC qualification - to date, yielding \$566million.
- Assessed IBM Watson for KP use/development using an open source leadership model.
- Built a new, highly functioning consulting group focused on developing, evaluating and spreading of promising and strategic KP HC practices to support/change regional inpatient and outpatient operations.
 - **Piloted and amplified use of telehealth at Kaiser** – Our team not only piloted the first telehealth application at Kaiser, but we expanded the term to include a variety of modalities: secure emails, televisits, pre and post visit questionnaires, These required assuring that accountability and fail-safe processes were in place.
 - **Predictive triage analytics** – Identified and/or developed predictive analytics to identify patients at risk and patients that could potentially benefit from treatment interventions.
 - **PROs – Patient reported outcomes.** Using direct patient responses as health outcomes. We piloted the first at Kaiser in oncology.
 - **Clinical decision support** - clinical protocols and judgement can be implemented/supported by technology in many subtle or intrusive ways.
 - **Reports and analytics** to evaluate the effectiveness of the operations, innovation or CDS (clinical decision support) for the ongoing and inevitable adjusting for operations improvement
 - **Natural language processing** – both to improve coding and also to identify key patient signals in progress notes, my team developed NLP code.
- Member of the IOM committee on Health Information Technology and Patient Safety; the IOM committee on EHR Digital Learning Collaborative project on ROI for EHRs

Senior Director, Clinical Systems Planning & Consulting – Program Office 2000- 2005

Ran strategy and analytic consulting department for Sr. VP –Hosp, Quality & Care Delivery Excellence. Initiated and led value realization development and analysis on the Electronic Health Record (EHR).

- Championed, conducted & published original evaluation analysis of EHR regional operations impacts. Led EHR business cases amounting to a projected \$4 billion in benefits realization over the next 10 years.
- Orchestrated the development of the 'Blue Sky Vision' – a strategic vision for the KP's care delivery in 2015.
- Sponsored, implemented and evaluated first KP pilot of the MyChart Personal Health Record and patient portal.

Project Director, Chronic Conditions Management (CCM) Program, TPMG, Northern CA 1999-2000

Managed development, implementation and ongoing support of population management of 9 conditions– a then new operations program to improve quality/efficiency. Coordinated analytic staff, financial staff, IT departments, department of Quality and Util, Health Educ and MD stakeholder groups to support medical centers' reengineering Adult primary care.

- Managed strategy; delivered funding decisions for \$37M program investment in population management: Asthma, Diabetes, Heart Failure, CAD, Cholesterol Facilitated initiation of 60+ CCM programs and consequent reporting and monitoring at medical ctrs with 140 staff extending care to 57,000 members.

Director of Business Planning, CA Division - Hospital/Health Plan Organization for California 1997-1999

Focal point for business planning activities for CA operations. Led regional/local efforts on target-setting process for CA Business Plan submission to national organization. Reported to Sr. VP, Planning and Analysis.

- Facilitated senior management discussions to develop financial performance challenge framework of turnaround plans for 1998-2001. This work set initial goals for organization (2%, 4% & 6% operating margin for 98-01).
- Initiated/coordinated reduction of short/mid-term capital spending plans by \$1.1B (from \$6.3B over 5 years).

Practice Leader for Strategic Alliances, Northern California Hospital and Health Plan 1995-1997

Co-led new inpatient service strategies/implementation. Reported to Managing Director, KP Consulting.

- Led team of medical center operations leadership, financial analysts, contacting specialists, planning consultants, outside consultants in South Bay (3 hospitals). Explored hospital alliance strategy. Coordinated negotiations with Stanford Hospital System enabling leadership to assess potential operations merger.
- Partnered with physician group to develop Inpatient Service Guidelines – thresholds of high volume inpatient services for quality/cost effectiveness for KP Northern California.

KP Health Plan Reengineering Project, Northern California Health Plan 1993–1995

Innovative re-engineering project on health plan services. Recommended and advocated for Member Services Call Center creation.

Planning Manager, Facilities Planning Northern California – KFH/HP 1990-1993

Oversight of planners/analysts facilitating capital decision-making. Supported medical centers with operations planning, space planning, cost/benefit analysis, forecasting of member demand for services/space and cashflow analysis/balancing.

Operations/Utilization Analyst - Medical Economics & Statistics, Northern California – KFH/HP 1983-6

Responsible for rate-setting and long-term capital planning membership, utilization and resource forecasting and reporting along with rates and benefits calculations and patient satisfaction surveys

AT&T, Corporate Headquarters, Basking Ridge, NJ

1987–1989.

Internal Statistical Consultant reporting to Director of Strategic Operations Analysis

Analysys, Limited, Cambridge, England

1986-1987

Consulting firm specializing in telecommunications econometric modeling for European Economic Community (EEC).

EDUCATION

Executive Leadership Program, ELP - Harvard Business School 2008

Masters in Biostatistics – MPH, University of California, Berkeley

Summer Program in Social Sciences in Mexico D.F., Colegio de Mexico

Engineering Degree in Operations Research, B.S.E., Princeton University

PROFESSIONAL DEVELOPMENT

- Green Belt Certified – Inst of Industrial Engr
- Total Quality Management / 6 Sigma
- Programmed in SAS, Pascal VS, Fortran
- CAP- Certified Analytic Professional: INFORMS Society
- Strategic Decision Making (SDG Group, Palo Alto CA)
- Certified Healthcare Insurance Executive – AHIP 2012

AFFILIATIONS / COMMITTEES

- KPLA – Kaiser Permanente Latino Association
2005 given the ‘KPLA Pathmaker’ Award
- SAS Customer Advisory Board 2013-5
- IOM Committee on Patient Safety & HIT 2010 /11
- Princeton Alumni Schools Committee 1988-2018
- British NHS Benefits Realisation and Achievement International Network (Brain) Member 2008-10
- Health Plan Institute Fellow
Latino Corp Directors Assoc. – 2020- current

Personal: Climbed Mt Kilimanjaro; enjoy golf, sports and adventure travel. 2 wonderful children from our 38 year marriage.

SELECTED PUBLICATIONS

- T. Garrido, D. Meng, J. Wang, T. E. Palen, M. Kanter, “Secure emailing between physicians & patients: transformation change in ambulatory care.” **J Ambulatory Care Manage**, Vol 37, No 3, pp 211-218 (June 2014)
- T. Garrido, S. Kumar, J. Lekas, M. Lindberg, D. Kadiyala, A. Whippy, B. Crawford, J. Weissberg, “e-Measures: insight into the challenges & opportunities of automating publicly reported quality measures” **J Am Med Inform Assoc** doi:10.1136/amiainl-2013-001789
- B. Lee, M. Turley, D. Meng, Y Zhou, T. Garrido, A. Lau, L. Radler, “Effects of Proactive Population-Based Nephrologist Oversight on Progression of Chronic Kidney Disease: A Retrospective Control Analysis,” **BMC Health Services Research**. 2012, 12:252
- Y. Y. Zhou, R. Unitan, J. J. Wang, T. Garrido, H. Chin, M. Turley, L. Radler “Improving Population Care with an Integrated Electronic Panel Support Tool,” **Population Health Management**, 2011 February; 14(1): 3–9
- T. Garrido, A. Chase, “Value and Quality.” L. Liang, **Connected for Health**. San Francisco, **Jossey Bass**; 2010; Y. Y. Zhou, M. H. Kanter, J. J. Wang, T. Garrido “Improved Quality at Kaiser Permanente Through E-Mail Between Physicians and Patients,” **Health Affairs**, Vol 29, No 7 (2010); 1370-1375.
- C. Chen, T. Garrido, D. Chock, G. Okawa, L. Liang “The Kaiser Permanente Electronic Health Record: Transforming and Streamlining Modalities of Care,” **Health Affairs**, Vol 28, No 2, (2009); 323-333.
- T. Garrido, L. Jamieson, Y. Zhou, A. Wiesenhal and L. Liang, “Effect of Electronic Health Records in Ambulatory Care: Retrospective, Serial Cross Sectional Study,” **British Medical Journal** 330.7491.581 (2005).
- T. Garrido, B. Raymond, L. Jamieson, L. Liang, A. Wiesenhal, “Making the Business Case for Hospital Information Systems,” **Journal of Health Care Finance** 31, no. 2 (2004):16–25.
- R. Brentari, T. Garrido, R. Mittman, L. Liang, A. Weiland, A. Wiesenhal, R. Cordova, in **The Permanente Journal**: “Blue Sky Care Delivery 2015, Part I,” Vol 7, No. 4, Fall 2003, pgs 47-50; “Blue Sky Part II: The Health Encounter,” Vol. 8, No. 1, Winter 2004, pgs 93-97; “Blue Sky Part III: The Chronic Care Encounter,” Vol. 8, No. 2, Spring 2004, pgs 71-75

FRANCIS ‘PANCHE’ CHANG

EDUCATION AND FELLOWSHIPS

- [2009 – 2024] Fulbright fellow, US State Dept., Washington, DC
2020 Fulbright Specialist, Casa de los Amigos, Mexico City, DF, Mexico
2016 Fulbright Specialist, Shanxi Medical University, Taiyuan, Shanxi, China
2013 Fulbright Specialist, SEWA Rural, Jhagadia, Gujarat, India
- [2003 - 2008] Wilson National Fellowship Program, Princeton, NJ
Woodrow Wilson Visiting Fellow
- [1998 - 2001] Rockefeller Brothers Foundation, New York, NY
Mentor, RBF Minority Teacher Fellows
- [1991 - 1994] Boston City Hospital/Kaiser Family Foundation
Kellogg National Leadership Fellow
- [1984 - 1985] The Rand Corporation, Santa Monica, CA
Pew Health Policy Career Development Fellow
- [1973 - 1976] Legal Services, San Jose and San Francisco, CA
Reginald Heber Smith Community Lawyer Fellow
- [1970 - 1973] Boston University Law School, Boston, MA
J.D. 1973
Co-founded legal services office in Boston Chinatown.
- [1966 - 1970] Brandeis University, Waltham, MA
A.B. 1970 (Politics and Sociology)
- [1957 - 1966] The Fay School, St. Mark’s School, Southborough, MA
Scholarship student, National Merit commendation.

PROFESSIONAL EXPERIENCE

[2014 – present] Patient Centered Outcomes Research Institute (PCORI), Washington, DC

Stakeholder reviewer

Grant reviews for IHS, IMRI, Opioids, PCS, PLACER funding mechanisms.

[2014 – 2020] Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), Bethesda, MD

Initial Review Group member, Health, Behavior and Context Subcommittee

Grant reviews for R01, R03, R25, K01, K23, K99 funding mechanisms.

**[2017 – 2018] Ravenswood Family Health Center, East Palo Alto, CA
*Strategic Business Advisor***

Strategic business development for \$27M East Palo Alto federally qualified health center. Began MediCal managed care contracting for Santa Clara County patients.

**[2011 – 2017] Asian Americans for Community Involvement, San Jose, CA
*Chief Operating Officer***

Chief operating officer of \$19M San Jose nonprofit. Led development of integrated mental health/primary care health homes whose provider teams coordinate care with risk attached. Headed patient navigation center, recognized by the Center for Medicare and Medicaid Services with a 2012 Health Care Innovations award. <https://innovation.cms.gov/innovation-models/health-care-innovation-awards/california> (Asian Americans for Community Involvement). Managed 2013 - 2014 New Access Point startup of Federally Qualified Health Center. <https://www.hrsa.gov/about/news/press-releases/archive> (Asian Americans for Community Involvement). Supervised 2014 electronic health records upgrades across 7 clinical practices, along with clinic renovation, new site startup, and voice/data system upgrades. Oversaw 2015 NCQA Patient Centered Medical Home Level 2 recognition.

**[2001 - 2010] Walter S. Johnson Foundation, Menlo Park, CA
*Executive Director***

Managed \$115M private family foundation, 3 staff.

Retooled grantmaking and budgeting for \$6M grants program. Revamped program areas and grant guidelines, overseeing program shift to education and workforce development for older youth. Moved offices, installed new computer network, renegotiated lease, restructured health benefits. Completed investment manager review, asset allocation review and audit rebid. Hired and trained program and administrative staff.

[1997 - 2001] **S.H. Cowell Foundation, San Francisco, CA**

Senior Program Officer

Managed \$3.8M Public Education, Affordable Housing grants portfolios, staff and consultants.

Brought forward representative grants in student achievement, teacher training and transitional housing for \$150M private family foundation. Developed pre-development revolving funds for charter school construction and for affordable housing site acquisition.

[1993 - 1997] **Kaiser Family Foundation, Menlo Park, CA**

Program Officer

Managed 4 year \$5.5M joint initiative (with the Robert Wood Johnson Foundation) on sociocultural barriers to health care for \$350M private family foundation. Developed guidelines, selected grantees, monitored results, oversaw evaluation and dissemination. Planned and implemented national forum on language services in health care.

Brought forward representative grants in telemedicine, health quality standards and judicial education.

[1991 - 1993] **Boston City Hospital, Boston, MA**

Director of Hospital Community Benefits

Started and accredited public hospital community benefits program for 280 bed public hospital.

Recruited physicians for affiliated health centers. Planned and implemented patient origin study for 16 hospital-based ambulatory clinics.

[1988 - 1991] **Bureau of Primary Care, Rockville, MD**

Acting Deputy, Policy

Policy deputy for federal agency overseeing community health centers.

Oversaw \$3M building rehabilitation/construction technical assistance program. Helped to develop financial performance indicators for 575 community health centers nationally.

[1976 - 1988] **South Cove Community Health Center, Boston, MA**

Executive Director, Assistant Administrator

Led growth of large Asian community health center as it tripled its patient visits to 75,000 per year, doubled its staff to 125 FTEs, and quintupled

its annual revenues to \$5.5M. Added new school health, adolescent, Southeast Asian refugee, and elderly services.

Obtained national foundation funding for community health insurance, elderly living at home and community thalassemia screening and treatment programs.

Helped to found national associations of Asian Pacific community health organizations and Chinese immigrant social service agencies.

**[1975 - 1976] Legal Aid Society of Alameda County, Oakland, CA
*Attorney***

Civil litigation on housing, consumer and domestic issues. Impact litigation on consumer and employment issues.

ACCREDITATIONS

Admitted to practice: California, Massachusetts, US Court of Appeals (1st Cir.), US Supreme Court.

Inactive Member: California State Bar, Massachusetts Bar.

PUBLICATIONS

Kong, G., Chang, Pancho, and Yogi, S., Bay Area Nonprofits: Myths and Realities, Nonprofit Sector Research Fund, The Aspen Institute, 1998.

Chang, Pancho and Fortier, Julia, Language Barriers to Health Care: An Overview. J. Health Care for the Poor and Underserved, 1998;9 (Supplemental):5-20.

Smith, Mark and Chang, Pancho, The Role of Race and Ethnicity in Health Services Research. Health Services Research, 1995:30(1):145-150.

Feldstein, Aaron, Chang, F., and Kucharski, J., Tryptophol-induced sleep in mice. Life Sciences, 1970:9:323-326.

PROFESSIONAL MEMBERSHIPS

Board of Directors, Channing House, Palo Alto, CA (2022 – present)

Finance Committee, The Health Trust, San Jose, CA (2019 – present)

Board of Directors, Cancer Prevention Institute of California, Fremont, CA (2010 – 2021, Audit Committee chair 2012 - 2017)

Board of Directors, Asian Health Services, Oakland, CA (2001 – 2011, President 2005 – 2011)

Board of Directors, Marine Science Institute, Redwood City, CA (2008 – 2010)

Examiner, Baldrige National Quality Award, National Institute of Standards and Technology, Washington, DC (2006, 2007)

Member, Committee on Group Insurance Programs, California State Bar (2003 – 2006)

Treasurer, Asian and Pacific Islander Health Forum, San Francisco, CA (1998 – 2002)

Treasurer, Legal Services section, California State Bar (1998 – 2000)

Executive Committee, Board of Directors, California Rural Legal Assistance, San Francisco, CA (1995 – 1999)

Trustee, The Boston Plan for Excellence in Education, Boston, MA (1990 – 1993)

Commissioner, Massachusetts Group Insurance Commission, Boston, MA (1990 – 1993)

Secretary, Chinatown Neighborhood Council, Boston, MA (1986 – 1993)

Trustee, Bunker Hill Community College, Charlestown, MA (1986 – 1992)

Trustee and President, Association of Asian Pacific Community Health Organizations, Oakland, CA (1984 – 1988)

Invited Reviewer, Community Development Financial Institutions Fund, US Department of the Treasury; Agency for Health Services Research, Bureau of Maternal and Child Health, Bureau of Primary Care, Office of Minority Health, US Department of Health and Human Services; National Endowment for the Arts; National Institutes for Health; Charter School and After-school Units, California Department of Education; Hewlett Foundation (1984 – present)

Chair, Asian Caucus, American Public Health Association, Washington, DC (1978 – 1982)

COMMUNITY ACTIVITIES

Volunteer, Cambodian Cultural Dance Troupe, San Jose, CA (2001 – present)

Committee Chair, Assistant Scoutmaster, Eagle Scout advisor, Boy Scout Troop 87, Mountain View, CA (1996 - 2018)

Trustee, The Brookline Foundation, Brookline, MA (1991 – 1993)

Corporator, The Childrens Museum, Boston, MA (1991 – 1993)

Corporator, New England Home for Little Wanderers, Boston, MA (1991 – 1993)

AWARDS

Brandeis University Distinguished Service award (1984).

Justice in Action award, Harry Dow Memorial Legal Assistance Fund (2010).

Silicon Valley Business Journal Excellence in Healthcare award (2014).