El Camino Health

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

Monday, May 1, 2023 – 5:30 pm
El Camino Health | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 995 3902 3271#. No participant code. Just press #.

PURPOSE: To advise and assist the El Camino Health (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 – 5:32 pm**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Carol Somersille, MD Quality Committee Chair	*public comment*	**possible motion 5:32 – 5:33**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair		**information 5:33 – 5:34**
4.	**PUBLIC COMMUNICATION**	Carol Somersille, MD Quality Committee Chair		**information 5:34 – 5:37**
5.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Quality Committee Meeting (04/03/2023) b. FY24 Committee Goals ***Information*** c. Report on Board Actions d. FY23 Pacing Plan e. FY23 Enterprise Quality Dashboard f. CDI Dashboard g. Core Measures h. QC Follow-Up Items	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 5:37 – 5:52**
6.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer		**discussion 5:52 – 6:02**
7.	**Q3 FY23 STEEEP DASHBOARD REVIEW**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:02 – 6:22**

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
8.	**EL CAMINO HEALTH MEDICAL NETWORK REPORT**	Shahab Dadjou, President, El Camino Health Medical Network Ute Burness, VP of Quality and Payer Relations		**discussion 6:22 – 6:42**
9.	**REVIEW & RECOMMEND FY24 ENTERPRISE ORGANIZATIONAL GOALS**	Holly Beeman, MD, MBA, Chief Quality Officer	*public comment*	**possible motion 6:42 – 6:52**
10.	**ADJOURN TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 6:52 – 6:53**
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair		**information 6:53 – 6:54**
12.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (04/03/2023) ***Information*** *Health and Safety Code Section 32155* b. Quality Council Minutes (04/05/2023)	Carol Somersille, MD Quality Committee Chair		**motion required 6:54 – 6:59**
13.	*Health and Safety Code Section 32155* **Q3 FY23 QUARTERLY QUALITY AND SAFETY REVIEW OF REPORTABLE EVENTS**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:59 – 7:09**
14.	*Health and Safety Code Section 32155* **CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer		**motion required 7:09 – 7:19**
15.	*Health and Safety Code Section 32155* **SERIOUS SAFETY/RED ALERT EVENT**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 7:19 – 7:24**
16.	**ADJOURN TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair		**motion required 7:24 - 7:25**
17.	**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**
18.	**ROUNDTABLE** • **QC Assessment**	Carol Somersille, MD Quality Committee Chair		**discussion 7:26 – 7:29**
19.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 7:29 – 7:30 pm**

Next Meeting: 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, April 3, 2023
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent	Others Present
Carol Somersille, MD		**Holly Beeman,** MD, MBA, CQO
Pancho Chang		**Dan Woods,** CEO
Philip Ho, MD		**Meenesh Bhimani,** MD, COO
Prithvi Legha, MD		**Cheryl Reinking**, DPN, RN, CNO
Jack Po, MD**		**Shreyas Mallur,** MD, ACMO
Krutica Sharma, MD		**Daniel Shih,** MD**
Melora Simon		**Tracy Fowler,** Director, Governance Services
John Zoglin		**Nicole Hartley,** Executive Assistant II

**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 5:31 pm by Chair Carol Somersille. A verbal roll call was taken. Ms. Simon joined at 5:35 pm. All other members were present at roll call and participated in-person or telephonically. A quorum was present.	
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	Ms. Hartley shared that we have one member of the Committee, Jack Po participating remotely due to Just Cause. Chair Somersille ask Dr. Po if there were any adults in the room. Dr. Po confirmed there were not.	
3. 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.	
4. PUBLIC COMMUNICATION	There were no comments from the public.	

5. CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. Dr. Sharma, Chair Somersille, and Mr. Zoglin requested to pull item 5d – FY23 Enterprise Quality Dashboard. Dr. Sharma commented about the Patient Experience LTR scores trending downward and asked what the other extreme looks like in comparison to the top box? Meenesh shared we recently looked at March data. The score range is 5 4 3 2 1 with 5 being high (top box) and 1 being low. Five surveys out of the approximately 600 rated a 1 or 2 so we have 97% positive responses. Currently, we are focused on moving 4s to 5s. Mr. Zoglin asked why on items 11 and 12 there is a delay in data. Dr. Beeman shared that for the OB measures, they look at every single case versus taking a sample size of the measure. Each chart gets abstracted and verified. CMQCC (California Maternal Quality Care Collaborative) informs our LeapFrog Safety grade and cannot be sped up. An option for these measures is to have them be on the STEEEP dashboard versus the monthly dashboard. In addition, there is discussion around changing or adding a measure to breastfeeding rates. Dr. Beeman will work with MCH (Maternal Child Health) on a more timely measure. Chair Somersille wanted to ensure we have it notated to stop reporting Elective Delivery Prior to 39 weeks gestation and update it to breastfeeding. Dr. Beeman shared that the update will be for FY24. Chair Somersille asked if the data scientist is working with the OBG/YN department about the risk factors that cause the C-Section rate to be higher. Dr. Beeman shared the information comes from CMQCC. Dr. Beeman will bring to the Quality Committee at a future meeting the improvement work in progress by Maternal Child Health team. **Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (03/06/2023); For information: (b) Report on Board Actions, (c) Value Based Purchasing Report (d) FY23 Enterprise Quality Dashboard (e) QC Follow-Up Items **Movant**: Chang **Second**: Simon **Ayes**: Somersille, Chang, Legha, Po, Simon, Sharma, Zoglin **Noes**: None **Abstain**: None **Absent**: Ho **Recused**: None	***Consent Calendar Approved*** ***Action****: Dr. Beeman to work with MCH on a timely measure.* *.*
6. CHAIR'S REPORT	Chair Somersille shared that staff is working on getting everyone on the Committee access to Boardvantage to provide access to Quality Committee specific documents. Chair	

	Somersille also extended an invitation for any Committee Member to attend one of the upcoming Quality Council meetings. Chair Somersille formally introduced Pancho Chang, Quality Committee's newest Committee Member, and shared that Terhilda Garrido will no longer be joining the Committee.	
7. PATIENT STORY	Cheryl Reinking, CNO shared a Press Ganey survey comment received by a patient following discharge from the hospital. The patient felt that the discharge process was rushed and there was no time to absorb the discharge instructions. Cheryl shared that there is collaboration with the Readmission Committee and Patient Experience to review the current discharge process. With visitors being able to come onsite now, including family members in the discharge instructions conversations will be helpful. A process is being reviewed for scheduling discharge instructions to give families an opportunity to plan to be here. Currently, discharge instructions are provided in written form and there are generic videos available. Cheryl is partnering with Deb Muro, CIO on creating customized videos based on the patient's need.	
8. REVIEW & APPROVE FY24 COMMITTEE PLANNING ITEMS	Dr. Holly Beeman, CQO opened the discussion to discuss the updated FY24 Committee Planning Items. **FY24 Committee Goals:** Mr. Zoglin asked about the third metric on goal 4, *positive score on annual committee assessment*, and what that means. Ms. Fowler shared we have not developed the assessment yet so a positive score has not been defined. Discussion occurred within the committee regarding goal 4 and how it would be measured and the consensus is there needs to be a baseline on the assessment so we need to have an initial assessment done prior to the beginning of FY24. Ms. Fowler will present the draft assessment at the May Quality Committee meeting. The Committee agreed to remove the words *Positive Score* and update to *Improvement on baseline metrics.* The Committee Goals and assessment will come back to the Committee in May. Mr. Zoglin asked about goal 5, Education Session with the Committee, and why Patient Experience aptitude was removed. Ms. Fowler shared that we are not limiting the goal to only Patient experience education. Discussion occurred within the committee and the consensus is to update goal 5 to *Participate in the training and development of the Committee*.	***Action**: Initial committee assessment and updated FY24 Goals to be shared with QC at the May meeting by Tracy.*

	QC Charter: Dr. Beeman shared that Sentinel Events (SE) and Serious Safety Events (SSE) should stay as part of the charter for Quality Committee. Ms. Simon asked that we stay in line with the SE & SSE reporting policy. Dr. Beeman shared there is no policy that dictates which events are brought to the Committee. Chair Somersille asked if every SE or SSE comes to the Committee and Dr. Beeman shared that it does not. Dr. Sharma asked if we can see trends regarding SEs and SSEs. Dr. Beeman shared that the Serious safety event rate is reported monthly on the Enterprise Quality Dashboard. And, annually Sheetal Shah provides a detailed review of the years' serious safety events, including a breakdown into the categories of serious safety events. The charter was approved with two changes to be implemented: • Specific duty #1 on page 3 to say something other than "ensure". Suggestion: "Advocate for" • Specific duty re: SSE remove PolicyStat as the repository and replace with Policy and Procedure management software. **Motion**: To approve the Quality Committee Charter with the noted changes **Movant**: Zoglin **Second**: Sharma **Ayes**: Somersille, Chang, Ho, Legha, Po, Simon, Sharma, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Quality Committee Charter Approved***
	FY24 Pacing Plan & FY24 QC Dates: Ms. Simon noted we should have the org goals presented and then approved in separate months. Chair Somersille shared that the May 2024 meeting will be occurring and that either March or April will be removed. The Committee discussed the options and came to a consensus to remove the April 2024 meeting, keep the May meeting and move the items paced to May to be shared in the March Meeting. This means the proposed quality org goals for FY2024 will need to be presented at the March 2024 meeting. Dr. Beeman acknowledged this and confirmed this was doable for the quality team. **Motion**: To approve the FY24 Pacing Plan with the noted changes **Movant**: Zoglin **Second**: Chang	***FY24 Pacing Plan and FY 24 Dates Approved***

	Ayes: Somersille, Chang, Ho, Legha, Po, Simon, Sharma, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None **Motion**: To approve the FY24 Quality Committee Dates with the noted changes **Movant**: Simon **Second**: Sharma **Ayes**: Somersille, Chang, Ho, Legha, Po, Simon, Sharma, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	
9. PROPOSED FY24 ENTERPRISE ORGANIZATIONAL GOALS	Dr. Holly Beeman, CQO presented the FY24 Enterprise Organizational Goal and highlighted the following: • Patient Experience – the measures will likely not change, but the targets may change • Quality – the memo describes where we want to focus on for FY24 • Ensure the measure that is selected translates well to the full board and influences/reflects how we are publicly perceived. • Based on the initial review of the preliminary spring Leapfrog grades and a recent CMS/Leapfrog crosswalk, the areas of focused improvement for FY24 are likely to be C. Difficile Infection, Catheter Associated Urinary Tract Infection (CAUTI) and Central Line Associated Blood Stream Infection (CLABSI). • Continue to focus on non-ventilator hospital acquired pneumonia, but not included in the HAC Index for FY24 A discussion occurred with the Committee regarding the intent of the goals and additional options that were considered. The committee is in support of having a HAC 2.0 index with C Diff, CAUTI, and CLABSI for the quality organizational goal for FY24.	
10. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 6:50 pm. **Movant**: Sharma **Second**: Chang **Ayes**: Somersille, Chang, Ho, Legha, Po, Simon, Sharma, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Adjourned to closed session at 6:50 pm***

11. AGENDA ITEM 16: RECONVENE OPEN SESSION/REPORT OUT	The open session reconvened at 7:14 pm. Agenda items 11-15 were addressed in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (03/06/2023), the Quality Council Minutes (03/01/2023), and the Credentialing and Privileges Report by unanimous vote by all committee members present.	
12. AGENDA ITEM 17: ROUNDTABLE	No additional comments.	
13. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 7:15 pm **Movant**: Zoglin **Second**: Legha **Ayes**: Somersille, Chang, Ho, Legha, Po, Simon, Sharma, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Adjourned at 7:15 pm***

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

_____

Nicole Hartley, Executive Assistant, II

Prepared by: Nicole Hartley, Executive Assistant, II
Reviewed by: Tracy Fowler, Director of Governance Services

El Camino Health

FY24 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: Chiefs/Vice Chiefs of the Medical Staff, physicians, nurses, and members from the community advisory councils, or the community at-large.

GOALS	TIMELINE	METRICS
1. Ensure the metrics included on the Quality Committee dashboards (Enterprise Quality, Patient Care and Patient Experience dashboard, and STEEEP) are in alignment with the enterprise strategic plan.	Q4FY23 review and update which measures to include on the FY24 quarterly board STEEEP report.	- Enterprise quality dashboard measures and targets - STEEEP dashboard measures and targets.
2. Monitor Quality, Patient Care and Patient Experience performance in accordance with the pacing plan to track progress towards achieving targets.	Q4FY23, review FY24 Incentive Goal recommendations for Quality, Safety and Patient Experience measures and targets.	- Monthly Enterprise dashboard measures with targets and performance - Quarterly STEEEP dashboard with targets and performance
3. Identify and reduce health care disparities for ECH patients.	Biannual report to Quality Committee FY24.	- Monitor the effectiveness of ECH activities to reduce health care disparities in the individuals we serve
4. Foster a culture of collaboration, transparency, and continuous improvement within the Quality Committee by implementing regular feedback mechanisms, encouraging open communication, and promoting a shared sense of responsibility for achieving quality outcomes.	Using closing wrap up time, review quarterly at the end of the meeting.	- Attend a minimum of 7 meetings in person - Actively participate in discussions at each meeting - Improvement on baseline metrics for the assessment (Initial assessment to be conducted prior to the beginning of FY24)
5. Participate in the training and development of the Committee.		- Attend a conference and/or session with a subject matter expert - Commit to ongoing learning as needed.

Chair: Carol Somersille, MD
Executive Sponsor: Holly Beeman, MD, MBA, Chief Quality Officer

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
QUALITY COMMITTEE MEETING MEMO

To: Quality Committee
From: Tracy Fowler, Director Governance Services
Date: May 1, 2023
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:

Since the last time we provided this report to the Quality Committee, the Hospital Board met once and the District met once. 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 for any meetings since the last Quality Committee

Board/Committee	Meeting Date	**Actions** (Approvals unless otherwise noted)
ECH Board	April 17, 2023	- Renewal of MV & LG Urology Panel Agreements - Medical Staff Bylaw Revisions - Credentialing and Privileges Report - Policies, Plans and Scopes of Services: • Physician Financial Arrangements – Review and Approval • Scope of Service: Endoscopy Department – Los Gatos
ECHD Board	March 28, 2023	- No approvals to report
Compliance and Audit Committee	April 26, 2023	- No approvals to report
Executive Compensation Committee	No meetings	- No approvals to report
Finance Committee	No meetings	- No approvals to report
Quality Committee	N/A	- N/A

El Camino Health

Quality, Patient Care, and Patient Experience Committee

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
STANDING AGENDA ITEMS												
Consent Calendar[1]		✓	✓		✓	✓		✓	✓	✓	✓	✓
Patient Experience Story		✓	✓		✓	✓		✓	✓	✓	✓	✓
Serious Safety/Red Alert Event (as needed)		✓	✓		✓	✓		✓	✓	✓	✓	✓
Credentialing and Privileges Report		✓	✓		✓	✓		✓	✓	✓	✓	✓
SPECIAL AGENDA ITEMS – OTHER REPORTS												
Quality & Safety Review of reportable events		✓			✓			✓			✓	
Board STEEP Dashboard Review		✓			✓			✓			✓	
El Camino Health Medical Network Report		✓			✓			✓			✓	
Annual Patient Safety Report			✓									
Patient Experience (HCAHPS)			✓									
Health Care Equity		✓	✓						✓			✓
Safety Report for the Environment of Care					✓							
PSI Report						✓						
Sepsis Mortality Index						✓						
Value Based Purchasing Report										✓		
HAC Index						✓						
Approve Quality Assessment & Performance Improvement Plan (QAPI)												✓
COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR												
Propose Committee Goals									✓			
Approve Committee Goals										✓		
Propose FY Committee Meeting dates									✓			
Approve FY Committee Meeting dates										✓		
Propose Organizational Goals										✓		
Finalize Organizational Goals											✓	
Propose Pacing Plan									✓			
Approve Pacing Plan										✓		
Propose QC Charter									✓			
Approve Charter										✓		

1: Includes Approval of Minutes (Open & Closed), Current FY Enterprise Quality Dashboard, Med Staff Quality Council Minutes (Closed Session), Progress Against FY Committee goals (Quarterly), Current FY Pacing Plan (Quarterly), Report on Board Actions, QC Follow Up Items, ED Patient Satisfaction (Sept), CDI Dashboard (Semi-Annual), Core Measures (Semi-Annual), Leapfrog (June)

El Camino Health

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: May 1, 2023
Subject: Enterprise Quality, Safety and Experience Dashboard through March 2023

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety and experience measure performance through March 2023 (unless otherwise noted)

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. Assessment:

A. Quality Measures

i. Hospital Acquired Condition Index (lower is better). This metric is a composite of the weighted rates of 5 component measures:

FY22 Baseline					
Metric	Num.	Den.	Rate	Weight	Weighted Rate
C. Difficile Infection	37	patient days	xxx	0.10	0.355
Surgical Site Infection	18	# surgeries	xxx	0.25	0.06
nvHospital Acquired Pneumonia	115	patient days	xxx	0.20	0.365
Falls	153	patient days	xxx	0.20	0.265
Hospital Acquired Pressure Injury	8	patient days	xxx	0.25	0.022
HAC Index				Sum »	1.066

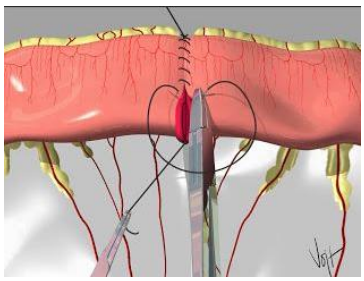
During March, the index was 0.90 which is favorable to target of 0.986. Year to date the HAC Index is 0.961, favorable to the FY23 target of 0.986.

1. **C. Difficile Infection:** There have been three C. Diff infections per month in the third quarter. This is unfavorable to our target of having < 2.85 infections on average per month. In-process measures to reduce C. Diff infection are accurate timing of testing and hand hygiene. Both are improving favorably.

a. Compliance with following our testing and screening procedure. Since October/November when we had several events which were classified as hospital acquired because of gaps in our testing and screening processes. This has been resolved with updating the standard procedure, and, more impactful, the robust education of our staff by our education team. We have not had a single occurrence of delayed or missed testing resulting in a 'false' hospital acquired infection.

b. Our hand-hygiene campaign has been effective. Secret shoppers measure hand-hygiene compliance. The # of observations has increased by 127% (from 1,113 to 2,537 per month). Compliance with hand washing with soap and water prior to exiting a C. Diff isolation room has increased to 91% from 40%. We still have work to do. We are encouraged by the progress our teams have made.

2. **Surgical Site Infection:** There has been one surgical site infection in the third quarter of FY23 (to date). This was a colon surgery post-operative infection on our Mountain View Campus. There have been a total of four colon surgery infections and one rectal surgery infection in FY23. All but one of these surgeries were performed laparoscopically. The bacteria cultured from the wounds of these cases grew out intestinal bacteria suggestive of anastomotic leaks. During resection of colon cancer, the cancerous colon segment is resected and the healthy colon segments on either side of the excised cancerous area are attached to one another (anastomosis) to recreate a continuous output track. This is a common source of 'leak'



and infection, which is why of all surgeries performed; colon resection surgery has one of the highest rates of surgical site infection. This area of surgical practice has our full attention.

The specific type of bacteria were different in each case as were the operating rooms where the surgery was performed, and, the surgical teams were different in each case. Since implementing utilization of a "clean closure tray" the peri-op teams have been tracking compliance with this practice. Both colon case SSI's since go-live of the clean closure tray did use a clean closure tray during surgery. The patients in each of these events had significant co-morbidities including invasive colon cancer, which increases their risk of an infection as the integrity of the colon tissue is compromised even before the surgery begins.

For perspective, 195-colon surgeries have been performed in FY2023 without infection.

3. **Non-ventilator Hospital Acquired Pneumonia (nvHAP)**—Year to date we are favorable to FY23 target and improved from prior year performance. Quality Manager, Theresa Legion RN, has identified NEW evidence-based data and best practice information that has published within the past 12 months to guide our approach to prevention of nvHAP. Our teams are focused on increasing oral care (brushing, rinse, etc.) to reduce risk of pneumonia. We have an opportunity to increase oral care compliance through clinical protocol redesign and staff and physician education.

4. **Patient falls on inpatient units—**March performance is favorable to target. Year to date, we are unfavorable to target. We project being at or below goal (favorable) at year-end. The results of the pilot exploring the impact of using EPIC cognitive computing a predictive analytics (Artificial Intelligence) to reduce falls demonstrated a

Falls Predictive Analytics Tool (Ann Aquino)

	Pre-Implementation	Control Group 4A	AI Test Group 4B
May – Aug 2022	Fall	2	3
	No fall	1270	1055
	Fall rate	0.16%	0.29%
	Post-Implementation		
Sept – Dec 2022	Fall	9	1
	No fall	1259	1015
	Fall rate	0.71%	0.10%

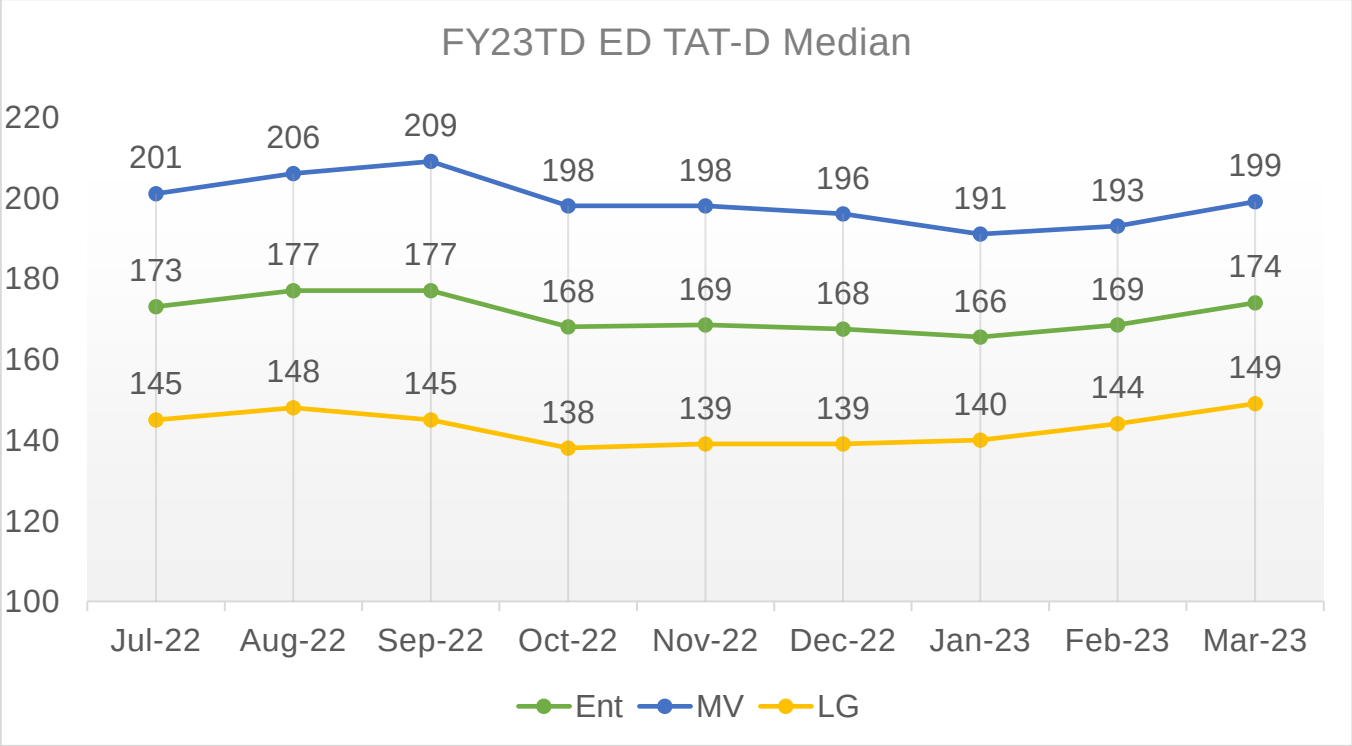
statistically significant decrease in falls, and, a statistically significant improvement in nurse's perception of AI.

ii. **Readmission Index:** February 2023 readmission index is favorable to target.

iii. **Sepsis Mortality Index:** Sepsis mortality for March and year to date is unfavorable to target. Sepsis mortality is affecting overall mortality unfavorably. Compliance with the sepsis bundle of treatment is low (42%). The in process measure of giving a fluid bolus within 3 hours of time of presentation is our greatest opportunity for improvement. Through the course of FY23 the "fluid bolus" intervention has decreased from 80% to 44% . We are currently collaborating with Information Technology to consider and vet implementation of an artificial intelligence tool; Sepsis DART™. Our current information technology capability does not allow for real-time feedback on patient condition and timely completion of bundle elements at the point of care. The Sepsis DART™ tool monitors and communicates regarding all aspects of sepsis treatment bundles to the right clinicians at the right time. It also maintains information on septic patients between care locations and shifting staff. If we do move forward with this AI solution, go live would not be for several months. In the interim, we look forward to collaborating closely with the newly hired Medical Director of the Emergency Department to identify how we can re-animate the engagement of staff/physicians for early detection and timely treatment of patients with sepsis.

iv. **PC-O2: Cesarean Birth (NTSV--nulliparous, term, singleton, vertex):** Core measure data for PCO-02 through December shows an improvement/reduction in cesarean section rates compared to the first quarter. Going forward in FY24 we will share more contemporaneous data on NTSV on our monthly enterprise dashboard. There are three categories of indications for a NTSV cesarean delivery; elective maternal choice/request, fetal indications, labor arrest/disorder. Our primary elective cesarean section rate is 3%, which is low compared to California benchmarks. The process improvement focus of the maternal child health team is on reducing the cesarean section rate for 'labor disorders'. Efforts to identify gaps and reduce cesarean section rates are described in the attached presentation "Maternal Child Health NTSV C Section Steering. March 2023".

v. **Emergency Department Turnaround Time for Pts Discharged from ED:** ED TAT-D (unfavorable): Emergency department turnaround time for discharged patient (ED TAT-D) is currently at a median of 171 minutes enterprise wide, with our goal being 164 minutes.



The Emergency Department in Mountain View has 32 beds, with 12 beds in Los Gatos. Annualized 2023 census in Mountain View projects to 57,395 (FY22 51,969) and in Los Gatos projects to 20,677 (FY22 17,088). This significant increase along with an increase in inpatient census has presented operational challenges. There are multiple factors that affect ED TAT-D, including inpatient bed capacity, mental health patient volume and holds, workflows and ancillary support (laboratory & radiology). Inpatient bed capacity is a significant driver of functional Emergency Department bed capacity as patients are frequently held in the Emergency Department waiting for an inpatient bed. Mental health patients often have prolonged stay awaiting assessment and disposition/transfer. Efforts to alleviate the overcrowding in Mountain View this FY have included operationalizing 5 additional observation beds (in endoscopy) and 4 additional treatment spaces for low acuity patients. We assembled a Process Improvement team in January to focus on reducing our ED TAT-D. The team has identified each of the components of the total ED TAT-D and assessed potential opportunities. We have identified and are focused on opportunities around:

- radiology turnaround times
- laboratory turnaround times
- disposition decision to discharge

B. Patient Experience Measures

i. **Inpatient Likelihood to Recommend:** Inpatient units overall did not meet goal for March but did see an improvement from February due to increased attention and focus on nurse leader rounding, communication and bedside shift report. Many units increased their scores including a record-breaking 2C (increased their power of 3 from 71% to 78% and their nurse leader rounding improved from 80% to 94%). Los Gatos exceeded their target and Med Surg in Los Gatos continues to do well with their increased focus. We

continue to emphasize being proactive and ensuring that the bedside shift report is happening. Coaching and supporting our leaders and new staff is also helping.

ii. **Maternal Child Health Likelihood to Recommend:** Mountain View MCH exceeded target again as did overall MCH. Improvements were seen in environmental categories such as noise, visitor and family accommodations. In addition, staff worked together, a key driver, also increased. The team continues to focus on proactive rounding and service recovery due to construction noise.

iii. **ED Likelihood to Recommend:** The ED dipped in March largely due to increased length of stay and holding patients in the ED waiting for an inpatient bed. A lot of work is being done to improve the efficiency of the lower acuity patients to ensure we decrease their wait times. Staff worked together, a key driver, increased also as we are working on our staffing models. We are definitely seeing an impact of having an ED Navigator on board to help with communication about wait times, service delivery and service recovery.

iv. **ECHMN Likelihood to Recommend Care Provider:** Will be reported on in the ECHMN quarterly report at this meeting. See separate ECHMN memo.

Attachments:

1. Enterprise Quality Safety and Experience Dashboard through March 2023
2. Maternal Child Health NTSV C Section Steering. March 2023

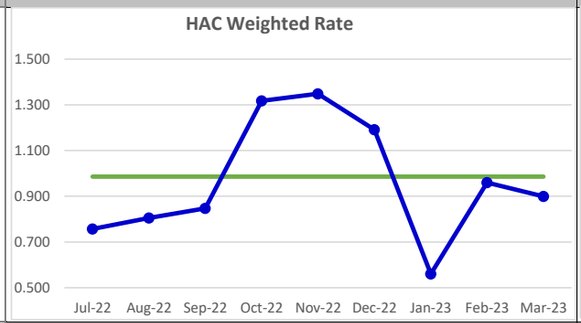
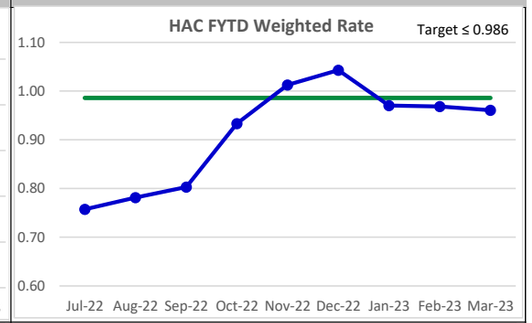
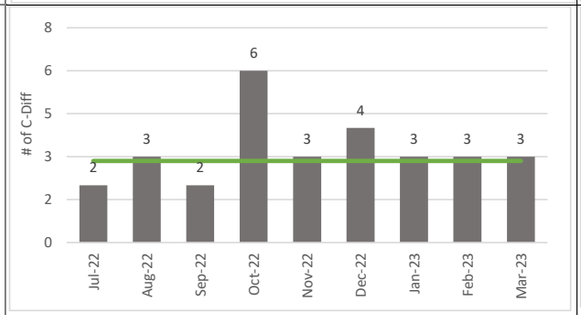
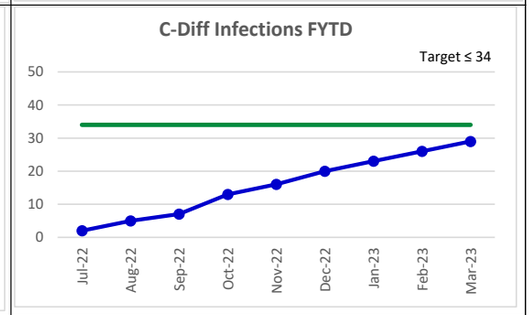
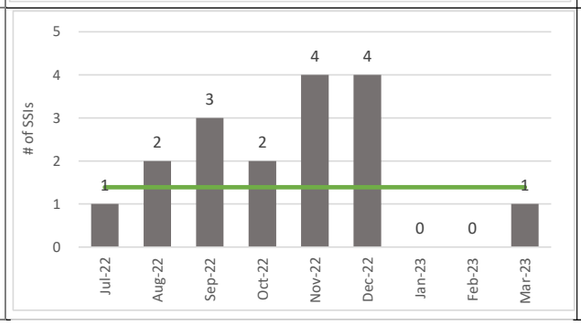
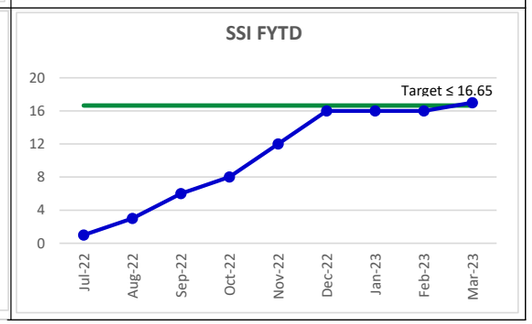
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

March 2023 (unless otherwise specified)

Month to Board Quality Committee:

May, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **HAC Index** *Latest data month: Mar, 23*	0.900	0.961	1.066	0.986 (7.5% ↓)		
2	HAC component **Clostridium Difficile Infections (C-Diff)** *Latest data month: Mar, 23*	3	3.22 / month	3.08 / month	2.85 / month		
3	HAC component **Surgical Site Infections (SSI)** *Latest data month: Mar, 23*	1	1.89 / month	1.50 / month	1.39 / month		

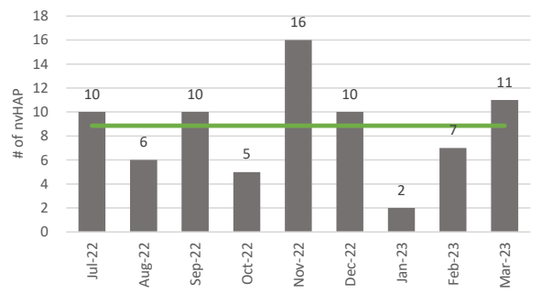
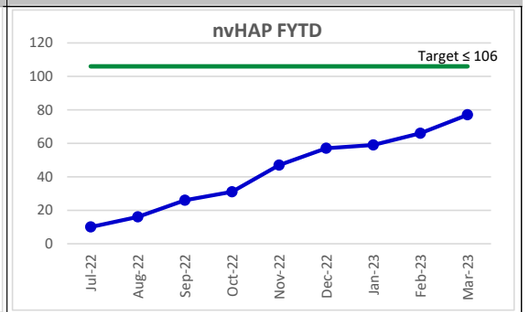
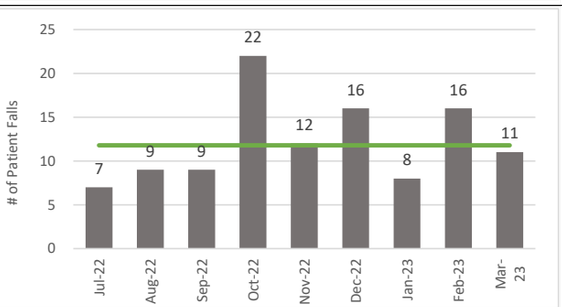
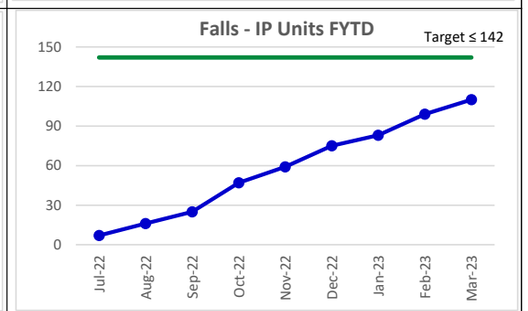
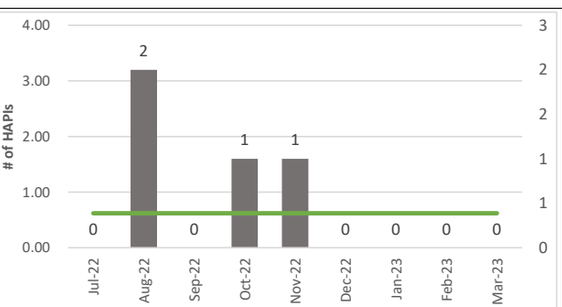
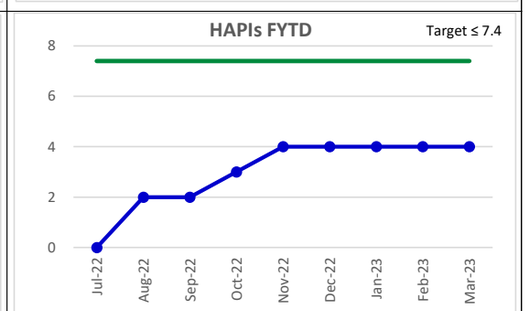
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

March 2023 (unless otherwise specified)

Month to Board Quality Committee:

May, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
4	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: Mar, 23*	11	8.56 / month	9.58 / month	8.86 / month		
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: Mar, 23*	11	12.22 / month	12.75 / month	11.79 / month		
6	**HAC component** **HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury** *Latest data month: Mar, 23*	0	0.44 / month	0.67 / month	0.62 / month		

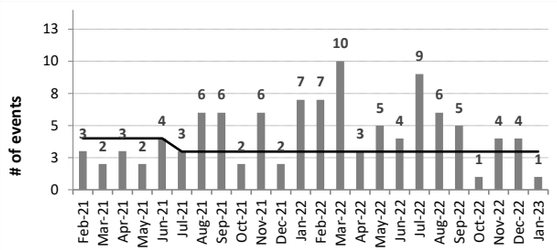
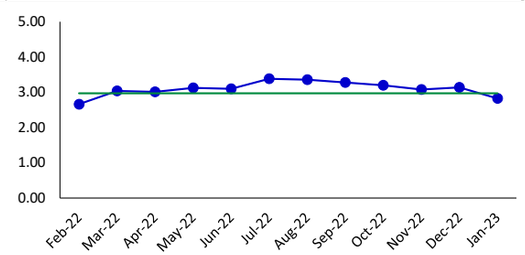
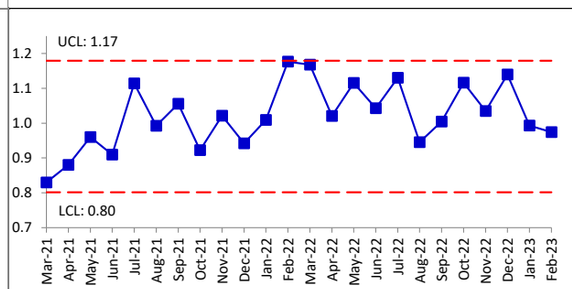
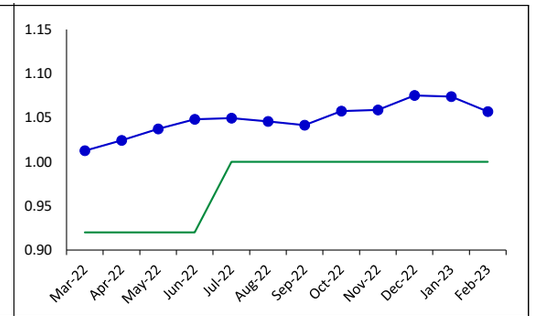
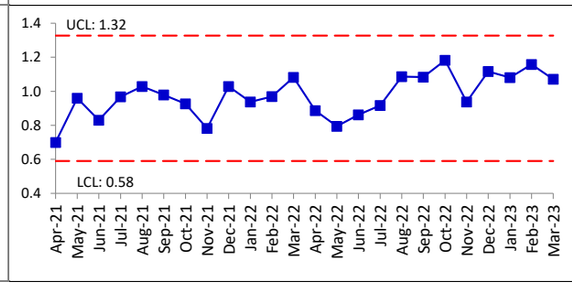
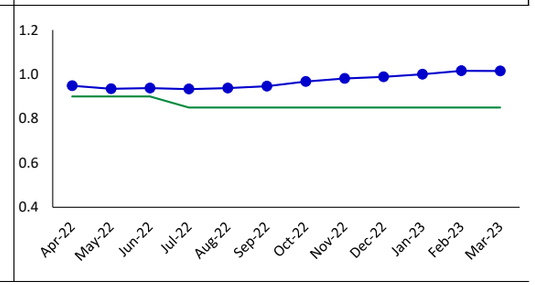
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

March 2023 (unless otherwise specified)

Month to Board Quality Committee:

May, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
7	**Serious Safety Event Rate (SSER)** **Latest data month: Jan, 23*	1	2.82 (59/208964)	3.10 (Jul, 21 - Jun, 22)	n/a		
8	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** ** Latest data month: Feb, 23*	0.97 (8.84%/9.08%)	1.04 (9.20%/8.82%)	1.05	1.00		
9	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Mar, 23*	1.07 (2.62%/2.45%)	1.08 (2.21%/2.05%)	0.94	0.85		

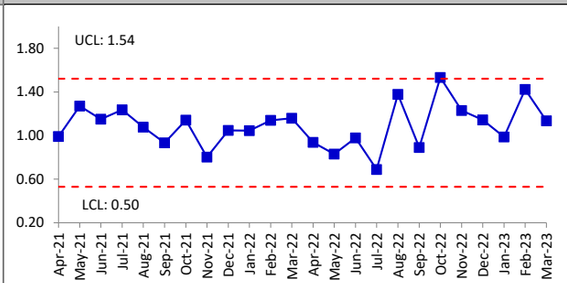
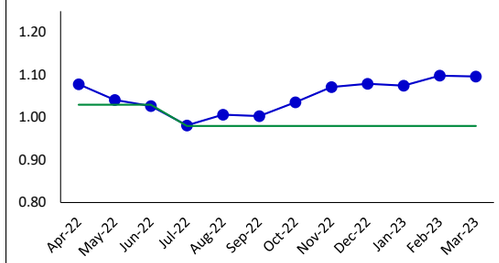
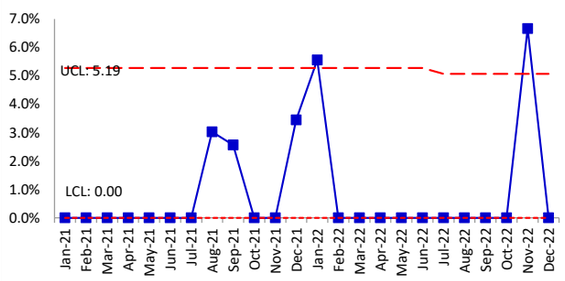
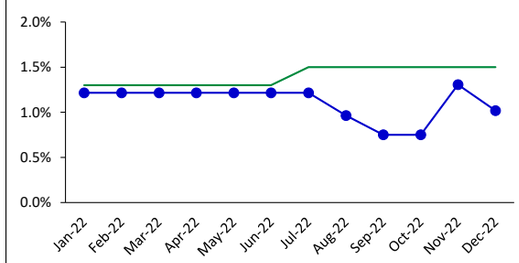
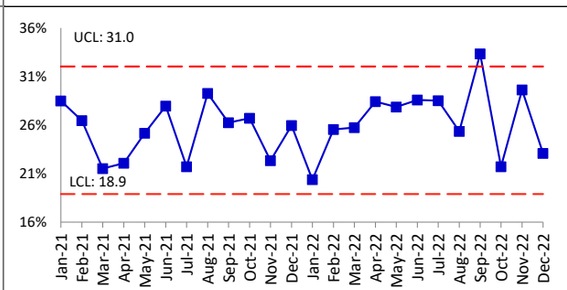
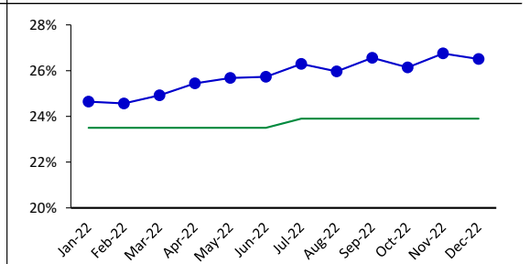
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

March 2023 (unless otherwise specified)

Month to Board Quality Committee:

May, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
10	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Mar, 23*	1.14 (15.25%/13.43%)	1.15 (14.08%/12.21%)	1.03	0.98		
11	**PC-01: Elective Delivery Prior to 39 weeks gestation** (reported quarterly) **Latest data quarter: Dec, 22*	MV: 0.0% (0/26) LG: 0.0% (0/5) ENT: 0.0% (0/31)	MV: 0.7% (1/137) LG: 0.0% (0/43) ENT: 0.6% (1/180)	MV: 0.4% (1/271) LG: 3.5% (3/83) ENT: 1.1% (4/356)	1.5% (FY23 Target)		
12	**PC-02: Cesarean Birth** (reported quarterly) **Latest data quarter: Dec, 22*	MV: 23.6% (35/148) LG: 19.0% (4/21) ENT: 23.1% (39/169)	MV: 27.7% (266/959) LG: 21.9% (39/178) ENT: 26.8% (305/1137)	MV: 27.1% (503/1,857) LG: 19.9% (83/147) ENT: 25.8% (586/2,274)	23.9% (FY23 Target)		

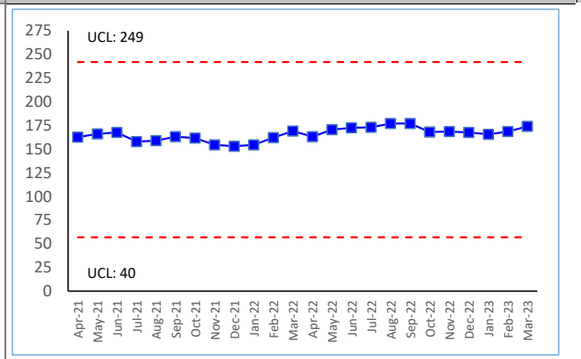
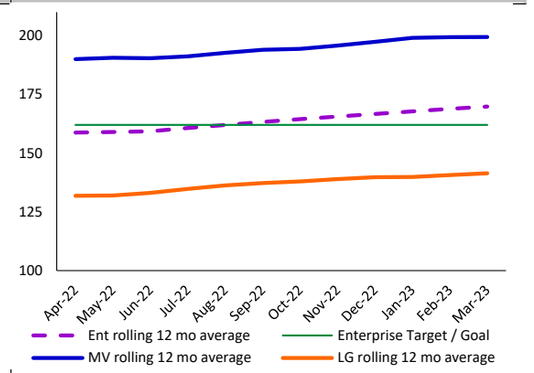
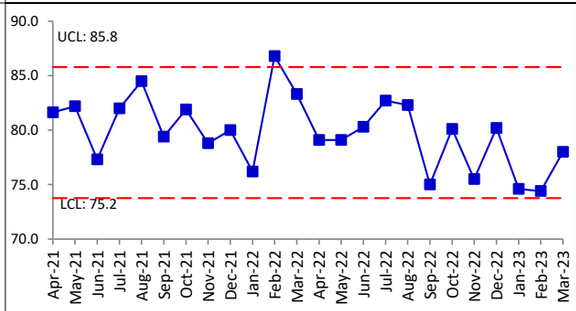
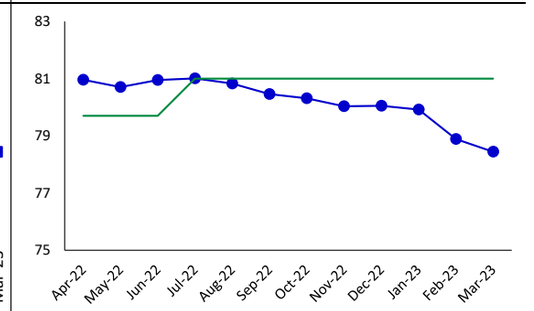
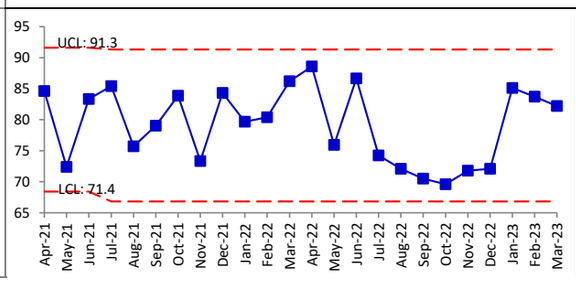
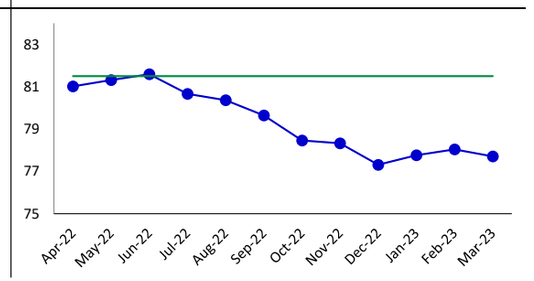
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

March 2023 (unless otherwise specified)

Month to Board Quality Committee:

May, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
13	**Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: Mar, '23*	MV: 199 mins LG: 149 mins ENT: 174 mins	MV: 199 mins LG: 143 mins ENT: 171 mins	MV: 190 mins LG: 133 mins Ent: 162 mins	MV: 190 mins LG: 133 mins Ent: 162 mins		
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Mar, 23*	78.0	78.5	80.8	81.0		
15	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Mar, 23*	82.2	75.3	81.3	81.5		

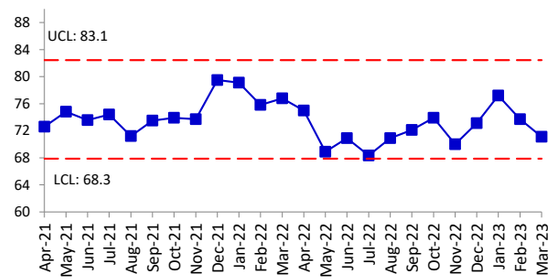
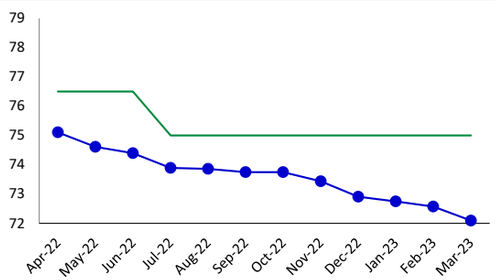
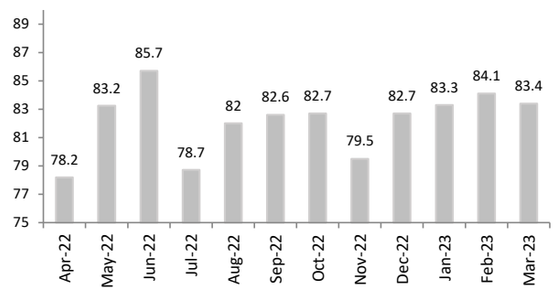
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

March 2023 (unless otherwise specified)

Month to Board Quality Committee:

May, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
16	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: Mar, 23*	71.1	72.1	68.4	75.0		
17	*** 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: Mar, 23*	83.4	82.2	83.2	83.4		NA

Notes:

1) SSER through Jan, 23
2) Readmissions through Feb, '23
3) PC-01 & PC-02 results available up to December 2022
4) ECHMN: reflect new vendor (PG) survey results
5) Updated 4/19/23

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
1	*Organizational Goal **HAC Index** *Latest data month: Mar, 23*		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	HAC component **Clostridium Difficile Infections (C-Diff)** *Latest data month: Mar, 23*		C. Nalesnik	1) Based on NHSN defined criteria: inclusions: Inpatients, Peri-Op, Behavioral Health; exclusions: Rehab, NICU, outpatients, ED patients 2) All positive C.diff Toxin/antigen lab tests that result on or after the patient's 4th day of hospitalization 3) Latency: C-Diff infections may be identified up to 30 days, thus previously reported results may change.	Numerator: Infection control Dept. Denominator: EPIC Report
3	HAC component **Surgical Site Infections (SSI)** *Latest data month: Mar, 23*		C. Nalesnik	1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty". 4) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. 5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.	Numerator: Infection control Dept. Denominator: EPIC Report

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
4	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: Mar, 23*		C. Delogramatic	1) Internal metric: Inpatient non-ventilator hospital-acquired pneumonia cases. 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. 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 5) Latency: periodic; corrections may change previously reported results.	EPIC Clarity data warehouse; Numerator identified by nvHAP workgroup; Denominator: EPSi patient days
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: Mar, 23*		Nursing	1) NDNQI metric: In or outpatient falls on an inpatient nursing unit. "Falls" in a nursery are 'drops'. 2) Numerator inclusions: Patient falls as determined by a monthly evaluation & validation of iSAFE incident reports. 3) Numerator exclusions: L&D, intentional falls. 4) Denominator: EPSi acute patient days excluding: 6900 Pre-OP/SSU, 7400 L&D, 7427 PACU 5) Formula: (# falls/patient days) * 1,000 6) Latency: rare; corrections may change previously reported results.	Numerator: Incident Reports and Staff Validation/iSafe Denominator: EPSi patient days
6	**HAC component** **HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury** *Latest data month: Mar, 23*		A. Aquino	1) Internal metric: Inpatient Stage 3, Stage 4 & Unstageable hospital-acquired pressure injuries 2) Numerator exclusions: Expirations, "skin failure/ Kennedy Pressure Ulcer" & proned Covid-19 patients 3) Denominator: EPSi acute patient days excluding 6070 NICU/Nursery Lvl 2, 6900 Pre-Op SSU,7400 L&D, 7427 PACU 4) Latency: periodic; corrections may change previously reported results.	Numerator: EPIC Report and staff validation Denominator: EPSi patient days

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
7	**Serious Safety Event Rate (SSER)** **Latest data month: Jan, 23*		S. Shah	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. 2) Inclusions: events determined to be serious safety events per Safety Event Classification team 3) NOTE: the count of SSE HAPIs MAY differ from internally-tracked HAPIs 4) Denominator: EPSI Acute Adjusted Patient Days For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero. New classification rules in effect as of 7/1/22	HPI Systems
8	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** * Latest data month: Feb, 23		H. Beeman, MD	1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause). 2) Based upon Premier's Care Sciences Standard Practice risk-adjustment + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient 4) NOTE: Excludes cases discharged from (1) hospital, then readmitted to the other hospital w/in 30D. For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Premier Quality Advisor
9	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** Latest data month: Mar, 23		H. Beeman, MD	1) Based upon Premier's Care Sciences Standard Practice RA for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient; exclusions: Patient Type = Rehab, Psychiatric or Hospice. For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= to zero.	Premier Quality Advisor

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
10	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Mar, 23*		J. Harkey, H. Beeman, MD	1) Numerator inclusions: Patient Type = Inpatient, Prin or 2nd diagnosis of sepsis & age 18+ yrs 2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB) For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Premier Quality Advisor
11	**PC-01: Elective Delivery Prior to 39 weeks gestation** (reported quarterly) *****Latest data quarter: Dec, 22*		H. Beeman, MD	1) Numerator: Patients with elective deliveries 2) Denominator: Delivered newborns with gestation weeks >/= 37 to 39 weeks For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value ,/= zero. 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.	IBM CareDiscovery Quality Measures
12	**PC-02: Cesarean Birth** (reported quarterly) *****Latest data quarter: Dec, 22*		H. Beeman, MD	1) Numerator: Patients with cesarean births 2) Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value ,/= zero. 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.	IBM CareDiscovery Quality Measures

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
13	**Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: Mar, '23*		J. Baluom	ED Arrival to ED Departure (TAT-D - Direct Discharge): This metric is the median arrival to patient discharged time from ED. This metric excludes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery Patients who arrive via the ED. **Time stamp is used for this calculation:** ED Arrival - Patient Arrived in ED (50) (ADT_ARRIVAL_DTTM in Clarity "F_ED_ENCOUNTERS" table) ED Departure Time - "ED_Departure_DTTM" in Clarity "F_ED_ENCOUNTERS" table	EDSBAR Tableau Dashboard; EDOC Monthly Meeting Dashboard
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Mar, 23*		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 '0' if value </= zero.	HCAHPS
15	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Mar, 23*		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 '0' if value </= zero.	HCAHPS

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
16	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: Mar, 23*		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 '0' if value </= zero.	Press Ganey
17	*** 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: Mar, 23*		C. Cunningham	Switched Vendor NRC to PressGaney in January 2022. Started reporting in FY 23 dashboards 'Top Box, Received Date, and Unadjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey

Notes:

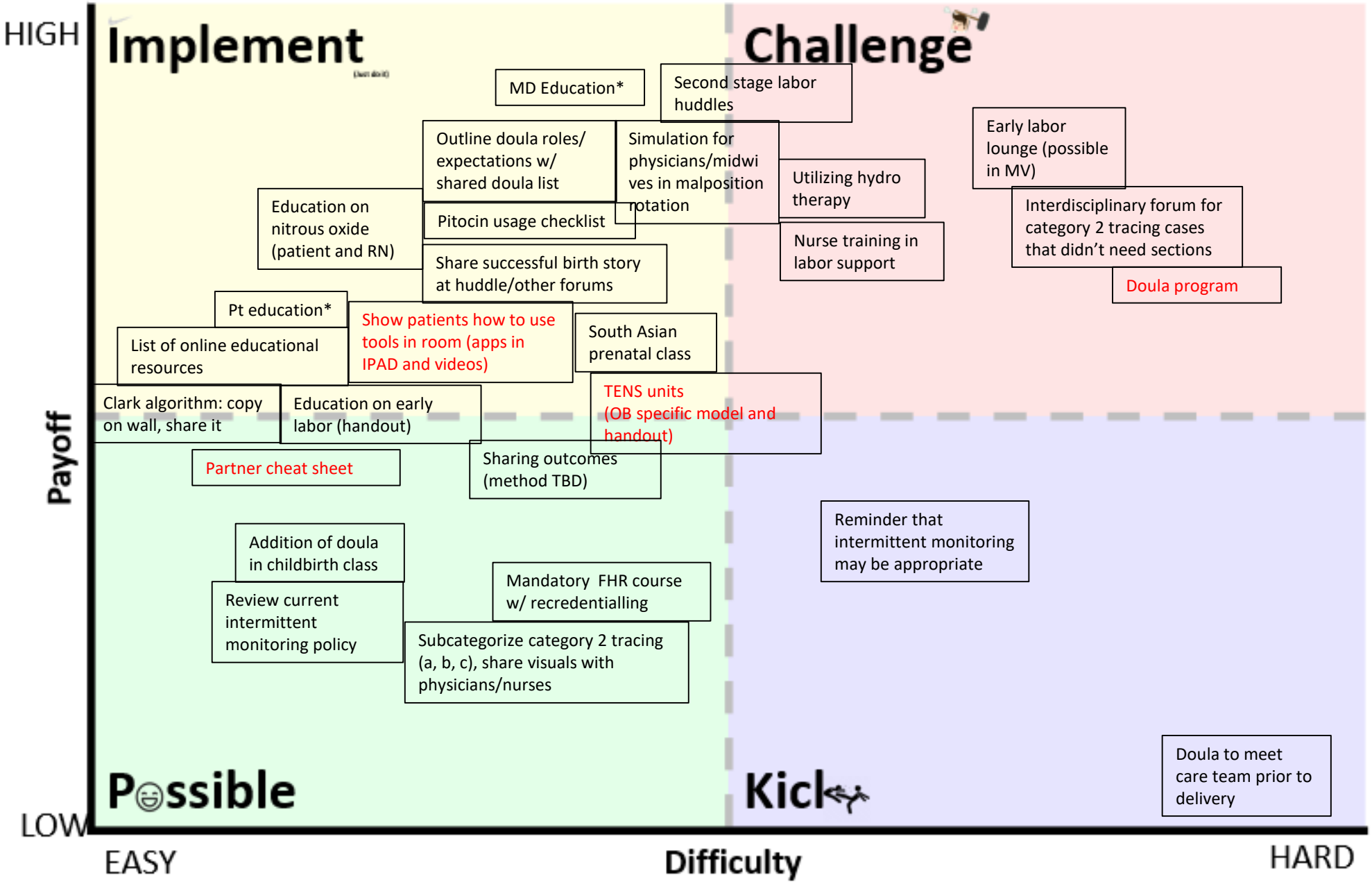
1) SSER through Jan, 23
2) Readmissions through Feb, '23
3) PC-01 & PC-02 results available up to Dec
4) ECHMN: reflect new vendor (PG) survey
5) Updated 4/19/23

Maternal Child Health NTSV Steering Committee
March 17, 2023

Toolkit Recommendation (Culture of Care, Awareness and Education	Current State	Interventions
Improve quality of and access to childbirth education	-Childbirth class- 3 hours -Cesarean prep- 2 hours Attendance for both classes is pretty close to registration numbers, but overall attendance is down - Infant CPR class in the works - Positioning is taught in tour - Healthy pregnancy for south Asians class in development (nutrition, exercise, etc)	- Educating patients to take these classes (leverage physicians and midwives) - Include induction patients on a weekly cadence into prep class for about 30 minutes - Potentially use social media to get information out to patients
Improve communication through shared decision making		
Bridge provider knowledge and skill gaps		
Improve support from hospital leadership		
Transition from paying for volume to paying for value		

Toolkit Recommendation (Supporting Vaginal Birth)	Current State	Interventions
Establish criteria for active labor admission	- Patients may be coming in early due to lack of education - Physician communication to patients in labor varies according to practices (independent vs group practices). Advice nurses may take the calls in the offices. - A lot of coaching currently from midwives before admission - Two standards for contraction intervals: 3-1-1 vs 5-1-1 - Different perspectives on receiving pain medication will affect when patients come in	- South Asian prenatal class in the works (nutrition, exercise, normal course of labor, when to come in) - Keep calm and labor on handouts for patients (including information in offices and classes) - Early labor lounge (2-3 cm contracting or lives far away) can stay there
Improve supportive care during labor	- Computer documentation and tasks may occupy nursing time - Gap in education on how to use a TENS unit for pain relief - Labor partner cheat sheet created in LG on how to support partner physically and emotionally - MV tubs' functionality unknown	- Morphine panel can be offered early on - TENS units help in controlling pain in early labor (30 mins to kick in). Indira ordered but engineering didn't approve in MV. Brand from UK designed for labor (difficulty in ordering). About $100-200. - Utilizing showers (high temperature is important) - Use of nitrous oxide (mandatory nursing education) - Training of nurses in labor support - Partner education class to support partner in labor - Show patients how to use tools that we have in the room
Integrate doulas	- Dynamic between doulas and hospital care team varies	- Role/expectations of doulas outlined clearly would be helpful (team mentality) - Possibility of doula to meet care team prior to delivery - Addition of doula in childbirth class
Best practices with epidurals	- Current dilation progression for epidural use (5-6 cm) - Challenge for nurses to be in the room every 30 minutes	- Expectation setting/education with regards to epidurals (5-6 cm) - Turning patients every 20-30 minutes
Encourage intermittent monitoring for low risk patients	- Intermittent monitoring may not be used in MV/LG	- Reminder that intermittent monitoring may be appropriate - Review current policy
Ensure availability of external cephalic versions	- Comfort level with performing versions varies - For those who are not comfortable doing it, MFMs can assist	- Getting an idea of which physicians are comfortable performing versions - Chiropractors may be able to assist in priming the body prior to turning to versions

Toolkit Recommendation (Managing Labor Abnormalities)	Current State	Interventions
Create highly reliable teams/improve team communication	- Nurses and physicians may have differing opinions on next steps for patient - No documentation on what was advised to the patient	- Team steps: introduce the idea of huddles on patients in more active labor - Second stage labor huddles (discuss location of head, manual rotation) to discuss next steps. Outside the room with primary OB, hospitalist, RN, charge. Bedside huddles are also an option. - Meet and greet w/ hospitalists and CNMs
Implement standard diagnostic criteria and algorithms to respond to labor dystocia and FHT abnormalities	- Pilot of checklist was done before you call C section for arrest - Nurses and physicians may have differing opinions on next steps for patient	- Be up to date on terminology on fetal heart rate monitoring (take a refresher course) - Subcategorize category 2 tracing (a, b, and c). Break them down into more meaningful categories. (Parer-Ikeda system) - Ensure people are following recommended guidelines to allow time for patients not yet in active labor (for arrest of dilation, calling c sections). - Pitocin usage checklist - Collecting reasons for calling c sections - Check in/check out on next steps for team to be aligned (physician led) regarding decelerations - Clark algorithm usage - Interdisciplinary forum to review category 2 tracing cases that had C sections (1:30pm and 4 pm). What about the category 2 a and b that went for vaginal delivery?
Use of operative delivery	- Hospital wide numbers are on par with a reasonable number within 5-6% range - Informed consent has variation on explaining pros/cons of operative delivery	- Additional training for physicians to better utilize the vacuums - Laminated card on risks/benefits of operative delivery (standardize)
Identify malposition, promote rotation from OP	- leverage spinning babies class	- Getting more nurses comfortable with identifying position - Use ultrasound to confirm position - Simulation training for physicians for malposition rotation techniques (need right pelvis and baby). Uses algorithm. In person and virtual are options.



Following recommended guidelines for allowing time for patients not yet in active labor

Collecting reasons for calling c sections

Labor dystocia checklist

Laminated card on risks/benefits on operative delivery and additional training for physicians using vacuums

Getting more nurses comfortable with identifying position

Nurse to ask hospitalist for ultrasound

Gaps	IF WE …	THEN WE EXPECT …	Notes
MD Education			doulas, TENS units, morphine sleep panel, not admitting patients until active labor, intermittent monitoring, ultrasound usage for confirming position
Outline doula roles and expectations w/ shared doula list			
Pitocin usage checklist			
Education on nitrous oxide (patient and RN)			
Share successful birth story at huddle/other forums			
Patient Education			Educate patients on taking childbirth class (epidural use), use social media to advertise for class, include induction patients into prep classes
Show patients how to use tools in room (apps in Ipad and videos)			
South Asian Prenatal Class			
Second stage labor huddles			
Simulation for physicians/midwives in malposition rotation			
TENS units (OB specific model and handout)			
Education on early labor (handout)			
Clark algorithm (copy on wall, share it)			

El Camino Health

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

To: Quality Committee of the Board
From: Cornel Delogramatic, Director of Clinical Documentation Integrity and Health Equity
Date: May 1, 2023
Subject: Clinical Documentation Integrity Dashboard FY 2020 - 2023

Purpose:

To provide a semi-annual update on the Clinical Documentation Integrity Department activity.

Summary:

1. Situation: From a clinical perspective, CDI ensures accurate descriptions of health conditions and creates electronic documents for every step of the patient's treatment and services that translates into quality outcomes (mortality score, readmission score, complication score, etc.), patient safety measures (PSI rate, HAC rate,) and utilization outcomes (expected LOS, denial rate, clean claim rate, RAF scores, CMI etc).

2. Authority: Quality Committee of the Board is responsible for oversight of Clinical Documentation Integrity Department.

3. Background: The Clinical Documentation Integrity (CDI) department is critical to a hospital because it ensures that clinical documentation accurately tells the patient's story and that the records of each patient and their medical history are maintained for future use. CDI programs can aid in the documentation of diagnoses that are specific and consistent throughout the medical record, which leads to accurate code assignment, better understanding of patient complexity, and improved safety and quality scores. Additionally, a well-trained clinical documentation integrity team will use consistent processes to promote accurate claims, which will reliably result in full reimbursement for rendered care services, reduce denials and improved appeal processes for the organization.

4. Assessment: Each medical record is reviewed by a clinical documentation specialist (CDS) who identifies documentation deficiencies or opportunities and uses a communication tool named "clinical documentation query" to communicate with the physicians to correct the deficiencies or to validate the diagnoses/procedures clinically. The CDI team is also responsible for educating the providers on documentation compliance requirements or newly emerged diagnostic guidelines, clinical classifications, and risk adjustment methodologies. Each query is stored within EMR as a part of the legal medical record.

In this dashboard, each metric that is higher is better and is highlighted in green.

5. Outcomes:

- **A.** CDI review coverage rate – Inpatient population; (process measure)
- **B.** CDI review coverage rate – Outpatient population; (process measure)
- **C.** CDI query volumes and provider meaningful responses; (process and engagement measure)
- **D.** PSI/HAC exclusion rates; (outcome measure)

E. Nv-HAP exclusion rates; (outcome measure)
F. Expected mortality rate at ECH; (clinical documentation derivative)
G. Expected readmission rate at ECH; (clinical documentation derivative)

List of Attachments:

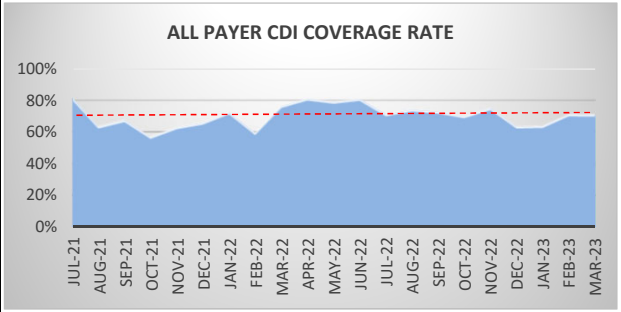
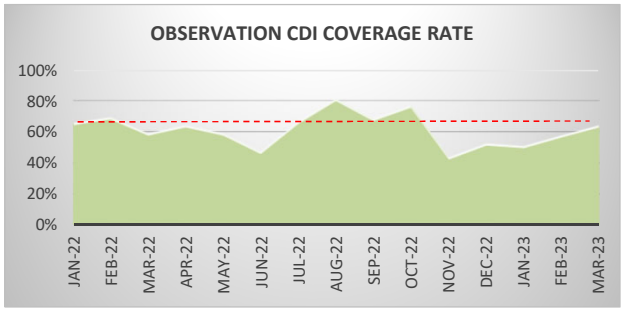
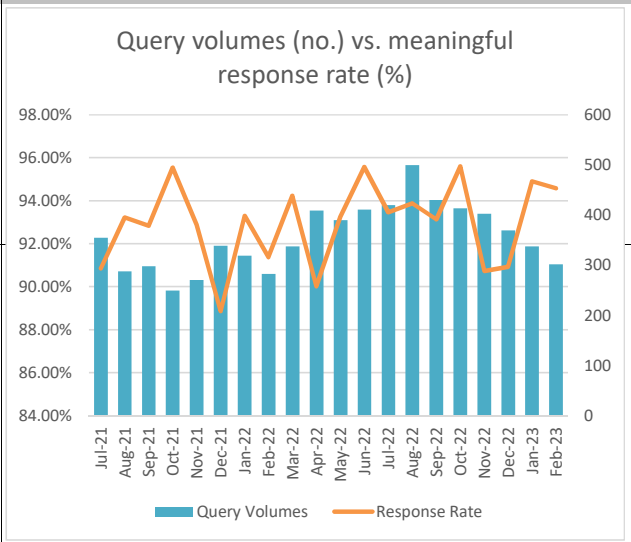
1. CDI Dashboard FY22.

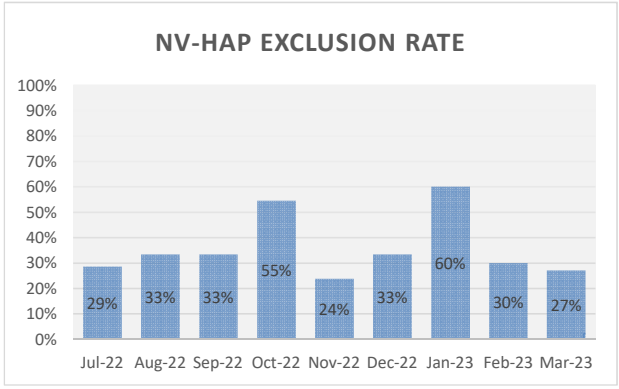
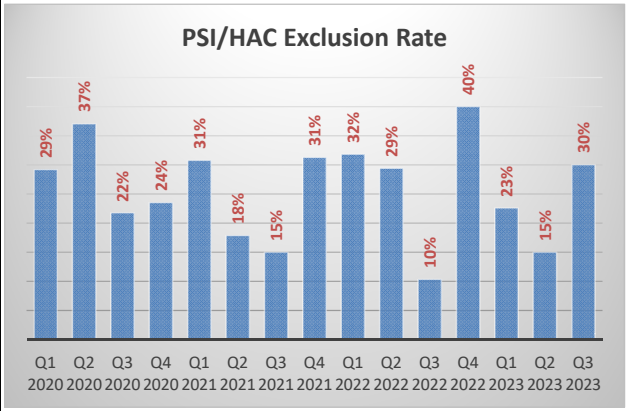
Suggested Committee Discussion Questions: None

El Camino Health

Clinical Documentation Integrity Dashboard (Monthly/ ALL adult, acute care, non-OB inpatient population)

As of Apr 15, 2022

				Baseline	FY23 Goal	Trend	Comments
CDI Coverage		**Performance**		**FY2022**	**FY2023 goal**		
1	**All Payer CDI coverage rate** **Source: iCare CDI Productivity report*	**March 2023** **71%**	**FYTD** **70%**	65%	70%		All-payer coverage demonstrates the effectiveness of the CDI Team. Currently, we have 4.5 FTEs covering all adult non-OB patients on both campuses. That is approximately 1300 to 1500 patients per month. We will continue implementing technologies to increase our productivity in FY 2024.
2	**Observation CDI Coverage Rate** **Source: iCare CDI Productivity report*	**March 2023** **64%**	**FYTD** **62%**	61%	65%		Observation review is essential for many aspects of the organization. By having clinical documentation specialists review these cases, we ensure that clinical documentation accurately reflects the medical necessity in the medical record and that all comorbidities are coded and clinically validated.
Physician engagement		**Performance**		**FY2022**	**FY 2022 goal**		
3	**Query volumes** **Source: iCare CDI Query report*	**March 2023** **309**	**FYTD** **362**	300	350		This metric is intended to assess physician engagement with CDI efforts within our health system by measuring the meaningful response rate compared to the total query volumes. Historically, CDI programs have shown progressive improvement in this metric within the past four years, increasing from 67% in FY 2019 to 94% YTD. Mainly it is up-trending due to strong CDI-MD collaboration and education around excellent clinical documentation benefits to the organization.
4	**Meaningful Response Rate** **Source: iCare CDI Query report*	**March 2023** **95%**	**FYTD** **94%**	87%	91%		

CDI Quality Outcomes		Performance		FY2022	FY 2023 goal		
#							
5	**nv-HAP exclusion rate** *Source: CDI nv--HAP dashboard*	**March 2023** **27%**	**FYTD Avg.** **36%**	–	**30%**		Nv-HAP is a central component of the HAC Quality Index. CDI team provides support by ensuring that each hospital-acquired pneumonia case is scrutinized and potential documentation challenges are clarified before being final coded and released for data collection. It is one of the many benefits a solid and experienced CDI team brings to the organization's quality and safety of care. A high exclusion rate of "false" labeled hospital-acquired cases of pneumonia positively impacts our HAC Index.
6	**PSI/HAC exclusion rate** *Source: CDI PSI/HAC Dashboard	**Q3 2023** **30%**	**FYTD Avg.** **23%**	**28%**	**30%**		Another aspect of CDI's impact on the quality of care and how that gets reported publicly is by reviewing Patient Safety Indicator (PSI) labeled cases and hospital-acquired conditions (HAC) and trying to clarify with the physician if any exclusion factors existed that could precipitate such safety events. By continuously monitoring these cases, the CDI team ensured our data gets reported accurately to federal reporting agencies and third-party entities that broadcast hospital ratings to the public. A high exclusion rate of inaccurately documented complications positively impacts our patient's care and the public's image of our institution.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
QUALITY COMMITTEE MEETING MEMO

To: El Camino Hospital Board Quality, Patient Care and Patient Experience Committee
From: Franz Encisa BSN MHA RN CPHQ
Director of Quality, Accreditation, Regulatory, Public Reporting
Date: May 1, 2023
Subject: Calendar Year 2022 Core Measure Dashboard

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on CY 2022 Core Measure Dashboard, Non-Hospital-based Inpatient Psychiatric Services Non-HBIP and Hospital-based Inpatient Psychiatric Services (HBIPS)

Summary: As required under section 1890A(a)(6) of the Social Security Act, Centers for Medicare and Medicaid Services (CMS) assesses the quality and efficiency of care provided to patients through establishing quality standards and programs to improve health care for beneficiaries and all who receive care in the United States. Core measures are designed to be meaningful to patients, consumers and physicians. The America's Health Insurance Plans (AHIP) leads the Core Quality Measure Collaborative (CQMC) which develops the core measures and their specifications. CMS uses core measure performance to inform how we are graded in various quality initiatives such as pay for reporting, value based pay, and public reporting on hospital compare.

1. 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 compliance with CMS measurements of clinical quality.

2. Background: There are no new revisions for CY 2022 by CMS or the Joint Commission (TJC) to the core measures. Some metrics are measured as eCQM (electronic Clinical Quality Measure) reporting in accordance with CMS "Meaningful Use" program. Sepsis (SEP-1) Core Measure is reported as its own dashboard. These measures only reflects Inpatient Quality Reporting (IQR) and some Outpatient Quality Reporting (OQR) Program Measures.

3. Assessment: CMS has two sets of Core Measures relevant to El Camino Health acute care: one covers acute hospitals (Non-HBIPS) and the second only applies to acute hospitals with inpatient behavioral health units, which is called HBIPS (Hospital-based Inpatient Psychiatric Services).

A. Non-HBIPS Core Measures (Non**-** Hospital-based Inpatient Psychiatric Services**)**

i. **PC01- Elective Delivery (EED)** Prior to 39 weeks gestation- Percent of mothers with elective vaginal deliveries or elective cesarean births at >=37 and < 39 weeks gestation completed. Maternal Child Health (MCH) continues to prospectively track EED and reach out to providers to reschedule as needed. When an EED occurs and was seemingly not indicated primary provider is contacted and informed that we are tracking and request is made to closely monitor and avoid unindicated EED. FY22 ECH Target = 1.5%, vs TJC <=2%. CY 2022 Performance: 0.6% (2/337).

Hospital Compare reporting period Q22021-Q12022 PC-01 - ECH 1%; national 2% and state 2%.

ii. **PC02- Cesarean Birth**- Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. Target goal of 23.9%; CY 2022 Performance is 26.5% (590/2226). The most recent quarter of data from CMQCC shows improvement with an NTSV rate of 23.2% enterprise wide. Of note, Leapfrog is following Healthy People 2020 NTSV cesarean birth rate target of 23.9% and 23.6% or less by 2030. Senate Bill 402, De Leon, Health and Safety Code 123367; Requires all general acute care hospitals and special hospitals with perinatal units to adopt, by January 1, 2025, ECH OB Task Force is working to identify where we can make system improvements to reduce unnecessary NTSV. MCH leadership team has worked with independent OBs and OB groups to identify practice patterns and opportunities for improvement. Currently each provider gets their personal score card twice a year so they can see how they are doing along with their peers.

iii. **PC05- Exclusive Breast Milk Feeding**- Newborns that were fed breast milk only since birth during the entire hospitalization. Target goal is 70%; CY 2022 Performance: 58.9% (505/858) which is below target, but above TJC's rate of 50%. Mother Baby Unit (MBU) has a taskforce committee for hand expressing breast milk, Lactation specialists provide information and support to breastfeeding. We offer outpatient consulting and a free drop-in support group. Los Gatos campus is a designated Baby-Friendly Hospital, recognizing that we offer an optimal level of care for breastfeeding mothers and babies. Nancy Held, RN, MS (Perinatal Clinical Nurse Specialist), IBCLC, joined the MBU team as the new manager for Lactation and Education Services (enterprise).

iv. **PC06- Unexpected Complications in Term Newborns**- this measure is intended to track moderate-to-severe adverse outcomes of healthy infants without preexisting conditions. Target goal is 0%; CY 2022 Performance: 2% (84/4182) compared to TJC's 3%. This measure is not publicly reported yet.

v. **OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients**-Median time (in minutes) patients spent in the emergency department before leaving from the visit. Target goal is 180 minutes or less; CY 2022 rate is ENT:192 minutes MV: 202 minutes. LG: 153 minutes. Latest Hospital Compare - ECH 178 minutes, California 192 minutes, and National average-202 minutes with reporting period 2Q2021 to 1Q2022.

vi. **OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke**- Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival. Target goal is 100%; CY 2022 performance is 83.3% (10/12) which has improved from FY2022 which was at 60%.

B. **HBIPS Core Measures (**Hospital-based Inpatient Psychiatric Services)

i. **IMM-2 Influenza Immunization** - Patients assessed and given influenza vaccination. Target goal is 100%; CY 2022 rate is 95%. IMM-2 Influenza California rate 78%; National 77% reporting period 4Q2021-1Q2022.

ii. **HBIPS-5 Patients Discharged on multiple antipsychotic medications with appropriate justification**. Target goal is 80% CY 2022 rate is 61%. Fallouts sent to MHAS team for further review and education to providers. This measure is part of OPPE. Usually providers will give justification which are not acceptable to CMS. Providers are encouraged to use the smart phrases already available in Epic discharge order.

iii. **PC-TOB Perfect Care - Tobacco Use**-Target goal is 80% CY 2022 rate is 38%. Variances sent to MHAS team for further review and education to providers. iCare modified tobacco order set to increase compliance. New Social workers were educated on tobacco counseling referral process. Quitline process is still efficient versus California Smoker's Helpline. Daily concurrent review of this measure includes participation of MHAS team – director, Manager, ACM/house supervisors, frontline staff and social workers.

iv. **PC-SUB Perfect Care - Substance Abuse**- Target goal is 80% CY 2022 rate is 95%.

v. **TR-1 Transition Record with Specified Elements Received by Discharged Patients.** Target goal is 75% CY 2022 rate is 85%.

vi. **MET-1 Screening for Metabolic Disorders** - Comprehensive screening currently defined to include: Body mass index, A1C or glucose test, Blood pressure, Lipid panel, Total cholesterol Low density lipoprotein, High density lipoprotein, Triglycerides. Target goal is 75%; CY 2022 rate is 94%.

vii. **HBIPS-2 Hours of Physical Restraint Use (per 1000 patient hours)** lower is better. Target goal is 0.0004; CY 2022 rate is 0.0002

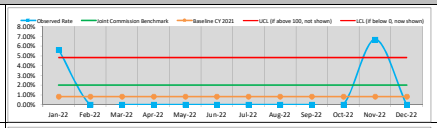
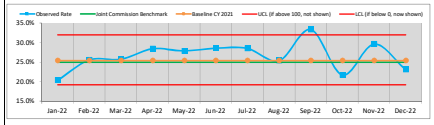
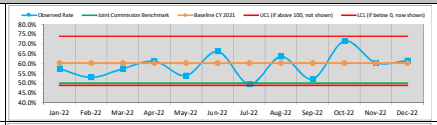
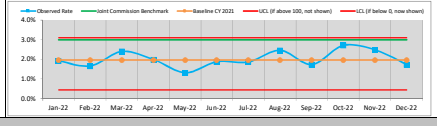
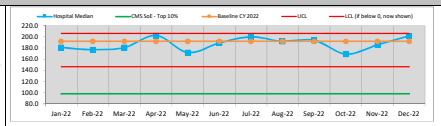
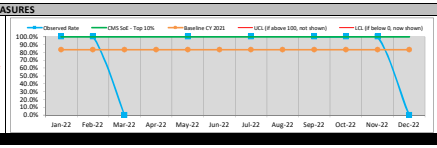
viii. **HBIPS-3 Hours of Seclusion Use (per 1000 patient hours**) lower is better Target goal is 0.0003; CY 2022 rate is 0.0002. Unusual high number of patients in restraint (8) and seclusion (8) in November 2022.

List of Attachments:

1. Attachment 1: CY2022 Core Measure Report Non-HBIPS for GB
2. Attachment 2: CY2022 Core Measure Report HBIPS for GB

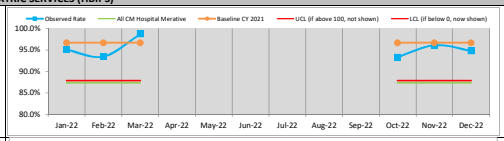
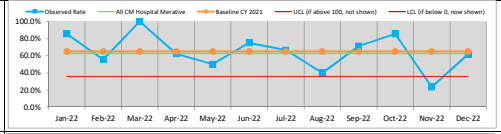
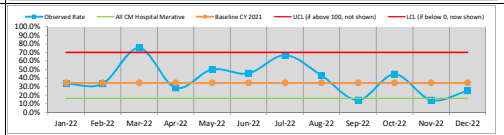
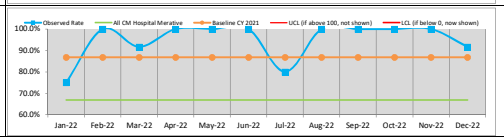
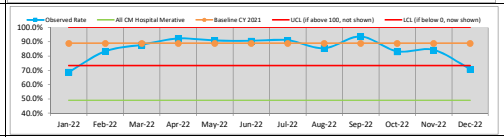
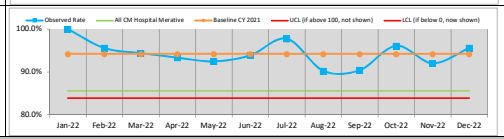
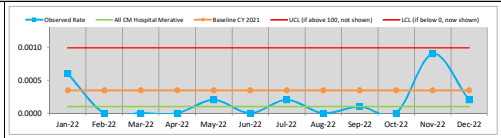
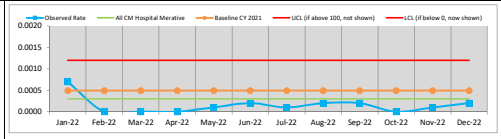
El Camino Health

Core Measures Dashboard (non-HBIPS) - CY 2022 Performance - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	CY 2022 Performance	Baseline CY 2021	Target	Trend Graph	Comments	CY 2022 Definition	Definition Owner	Work Group	Source
PERINATAL CARE MOTHER										
PC-01 Elective Delivery Prior to 39 weeks gestation (lower = better) **FINALIZED** *Data Source : Merative* *Latest Data Month: December 2022*	ENT: 0.0% (0/31) MV: 0.0% (0/26) LG: 0.0% (0/5)	ENT: 0.6% (2/337) MV: 0.4% (1/256) LG: 1.2% (1/81)	ENT: 0.8% (3/365) MV: 0.4% (1/279) LG: 2.3% (2/86)	2% (Joint Commission Benchmark)		PC01- Elective Delivery Prior to 39 weeks gestation- Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery wasn't medically necessary. Also known as Early Elective Delivery (EED) Target goal is 1.5%; CY 2022 Performance: 0.6% Statistically topped out national 2% and state 2% and was recently removed from Value Based Purchasing Program. MCH has an EED tracking system and reach out to providers to reschedule as needed. EED is tracked and closely monitored to avoid unindicated cases.	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to peer review coordinator	Merative CareDiscovery Quality Measures
PC-02 Cesarean Birth (lower = better) **FINALIZED** Data Source : Merative Latest Data Month: December 2022	ENT: 23.1% (39/169) MV: 23.6% (35/148) LG: 19.1% (4/21)	ENT: 26.5% (590/2226) MV: 27.8% (515/1850) LG: 19.9% (75/376)	ENT: 25.4% (534/2105) MV: 26.5% (451/1704) LG: 20.7% (83/401)	25% (Joint Commission Benchmark)		PC02- Cesarean Birth- Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. Target goal of 23.9%; CY 2022 Performance is 26.5% The providers get their score card generally every quarter so they can see how they are doing along with their peers;OB Task Force has been evaluating where they can make system improvements to reduce unnecessary NTSV.	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator	Merative CareDiscovery Quality Measures
PERINATAL CARE BABIES										
PC-05 Exclusive Breast Milk Feeding **FINALIZED** Data Source : Merative Latest Data Month: December 2022	ENT: 61.4% (43/70) MV: 63.2% (36/57) LG: 53.8% (7/13)	ENT:58.9% (505/858) MV: 57.0% (407/714) LG: 68.1% (98/144)	ENT: 60.2% (481/799) MV: 57.7% (376/652) LG: 71.4% (105/147)	50% (Joint Commission Benchmark)		PC05- Exclusive Breast Milk Feeding- Newborns that were fed breast milk only since birth during the entire hospitalization. Target goal is 70%; CY 2022 Performance: 58.9% Our target compliance rate of 70%- this gives us 30% allowance for cases with maternal /infant indicators to supplement with formula feeding. Medical reasons are not given credits or exempted e.g. Jaundice with TsB @ high risk or requiring phototherapy, hypoglycemia, weight loss >7% and dehydration. • Senate Bill 402, De Leon, Health and Safety Code 123367; Requires all general acute care hospitals and special hospitals with perinatal units to adopt, by January 1, 2025, The Ten Steps to Successful Breastfeeding adopt baby friendly 10 steps to successful breastfeeding	Numerator Statement: Newborns that were fed breast milk only since birth Denominator Statement: Single term newborns discharged alive from the hospital	TJC	Quarterly meeting/emails with L&D nursing leadership	Merative CareDiscovery Quality Measures
PC-06 Unexpected Complications in Term Newborns (lower = better) **FINALIZED** Data Source : Merative Latest Data Month: December 2022	ENT:1.7% (6/344) MV: 2.0% (6/296) LG: 0% (0/48)	ENT: 2.0% (84/4182) MV: 1.8% (63/3425) LG: 2.8% (21/757)	ENT: 2.0% (79/4028) MV: 1.7% (56/3249) LG: 3.0% (23/779)	3% (Joint Commission Benchmark)		PC06- Unexpected Complications in Term Newborns- TJC's new core measure is intended to track moderate-to-severe adverse outcomes of healthy infants without preexisting conditions. Target goal is 0%; CY 2022 Performance: 2.0% This measure is intended to track moderate to severe adverse outcomes of healthy infants without pre-existing conditions. Failed cases are referred to peer review coordinators/ nurses for further investigation.	Numerator Statement: Newborns with severe complications and moderate complications Denominator Statement: Liveborn single term newborns 2500 gm or over in birth weight. This measure simply asks: of babies without preexisting conditions (no preemies, multiple gestations, birth defects or other fetal conditions) and who are normally grown and were not exposed to maternal drug use, how many had severe or moderate neonatal complications?	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator	Merative CareDiscovery Quality Measures
ED THROUGHPUT										
OP-18b Median Time from ED Arrival to ED Departure for Discharged ED Patients (lower = better) **FINALIZED** Data Source : Merative Latest Data Month: December 2022	ENT: 202 mins MV: 205 mins LG: 160 mins	ENT: 192 mins MV: 202 min LG: 153 min	ENT: 177 mins MV: 185 min LG: 134.5 min	< 98 mins (CMS Standard of Excellence - Top 10% of Hospitals)		OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients-Median time patients spent in the emergency department before leaving from the visit. Target goal is 180 minutes or less; CY 2022 rate is ENT:192 mins; MV:202 mins; LG:153 mins	"Numerator -Time (in minutes) from ED arrival to ED departure for patients discharged from the ED - Reporting Measure Denominator -Any ED Patient from the facility's emergency department, not expired Included Populations: Any ED patient from the facility's emergency department Excluded Populations: Patients who expired in the emergency department"	Hospital OQR Specifications Manual		Merative CareDiscovery Quality Measures
OUTPATIENT MEASURES										
OP-23 Head CT or MRI Scan Results fro Acute Ischemic Stroke or Hemorrhagic Stroke **FINALIZED** Data Source : Merative Latest Data Month: December 2022	ENT: 0% (0/1) MV: 0% (0/1) LG: no case	ENT: 83.3% (10/12) MV: 90% (9/10) LG: 50% (1/2)	46.7% (7/15)	100% (CMS Standard of Excellence - Top 10% of Hospitals)		OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke- Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival.Target goal is 100%; CY 2022 83.3% The metric only includes patients who arrive within 2 hours of last known well explaining the low denominator . Currently, we are a Thrombectomy-capable Stroke Center in MV and Primary Stroke Center in LG so we continue to transfer certain cases to align with insurance and/or for higher level of care (primarily SAH cases in MV, and possible thrombectomy cases in LG.)	Numerator -ED Acute Ischemic or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the time last known well, with an order for a head CT or MRI scan whose time from ED arrival to interpretation of the Head CT scan is within 45 minutes of arrival Denominator -ED Acute Ischemic or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the time last known well with an order for a head CT or MRI scan	Hospital OQR Specifications Manual	Shared with Christine Kilkenny (monthly) /Stroke Committee (quarterly prn)	Merative CareDiscovery Quality Measures

El Camino Health

Calendar Year 2022 Performance - Core Measures (HBIPS) - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	CY 2022 Performance	Baseline CY 2021	All Core Measures Hospitals Jan-Dec 2022 Benchmark	Trend Graph	Comments	CY 2022 Definition	Definition Owner	Work Group	Source
HOSPITAL BASED INPATIENT PSYCHIATRIC SERVICES (HBIPS)										
IMM-2 Influenza Immunization FINALIZED *Data Source : Merative* *Latest Data Month: December 2022* ***Data only capture for Jan-Mar, Oct - Dec months***	94.8% (73/77)	95.1% (391/411)	96.7% (380/393)	87.3%		IMM-2 Influenza Immunization Patients assessed and given influenza vaccination. Target goal is 100%; CY 2022 rate is 95.1%	Numerator: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated. Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October through March. Excludes patients less than 6 months of age, patients who expire prior to hospital discharge, patients with an organ transplant during the current hospitalization, patients with hospital discharges Oct 1 through March 31 when the provider's vaccine supply is on order but has not yet been received, patients who are transferred or discharged to another hospital, or patients who leave AMA. Definition: Documentation of the patient's vaccination status during this influenza season. If found to be a candidate for the influenza vaccine, documentation that the influenza vaccine was given during this hospitalization.	CMS/TJC	quarterly meeting/ monthly email to MHAS team	Merative CareDiscovery Quality Measures
HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification FINALIZED *Data Source : Merative* *Latest Data Month: December 2022*	61.5% (8/13)	61.3% (73/119)	65.2% (88/135)	62.7%		Patients Discharged on multiple antipsychotic medications with appropriate justification. Target goal is 80%; CY 2022 rate is 61.3% Reports were created and shared monthly to BHS leadership to identify patients discharged on two or more antipsychotic medications without appropriate supporting documentation. Education efforts targeted to remind providers that even if they prescribed antipsychotic (e.g. Abilify) to treat depression, it's still counted as antipsychotic. Also not to bypass or work-around the hardwired discharge documentation of reason for 2 or more antipsychotics by answering NO.	Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification Denominator Statement: Psychiatric inpatient discharges	TJC	quarterly meeting/ monthly email to MHAS team	Merative CareDiscovery Quality Measures
PC-TOB Perfect Care - Tobacco Use FINALIZED *Data Source : Merative* *Latest Data Month: December 2022*	25% (1/4)	38.0% (27/71)	34.4% (11/32)	16.3%		PC-TOB Perfect Care - Tobacco Use-Target goal is 80% CY 2022 rate is 38% Each element has to be met to pass the measure. Current improvement work related to these measures includes Social Worker's Quitline referral, prescribing of FDA approved tobacco cessation drugs while inpatient and upon discharge. . Daily monitoring to identify current tobacco users to ensure proper interventions are implemented- quality collaborating with MHAS asst. clinical managers and hospital supervisors.	No tob 1 , same Tob 2 and 3	TJC	quarterly meeting/ monthly email to MHAS team	Merative CareDiscovery Quality Measures
PC-SUB Perfect Care - Substance Abuse FINALIZED *Data Source : Merative* *Latest Data Month: December 2022*	91.7% (11/12)	95.3% (122/128)	86.8% (46/53)	66.8%		PC-SUB Perfect Care - Substance Abuse- Target goal is 80% CY 2022 rate is 95.3%	No Sub 1, same SUB 2 and 3	TJC	quarterly meeting/ monthly email to MHAS team	Merative CareDiscovery Quality Measures
TR-1 Transition Record with Specified Elements Received by Discharged Patients FINALIZED Data Source : Merative Latest Data Month: December 2022	70.9% (56/79)	85.4% (719/842)	89.0% (717/806)	49.0%		TR-1 Transition Record with Specified Elements Received by Discharged Patients Target goal is 75% CY 2022 rate is 85.4%	Numerator: Psychiatric inpatients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all 11 required elements. Denominator: Psychiatric inpatients, regardless of age, discharged from the IPF to home/self-care or any other site of care.	CMS/TJC	quarterly meeting/ monthly email to MHAS team	Merative CareDiscovery Quality Measures
MET-1 Screening for Metabolic Disorders FINALIZED Data Source : Merative Latest Data Month: December 2022	95.6% (43/45)	94.2% (533/566)	94.2% (551/585)	85.5%		MET-1 Screening for Metabolic Disorders - Comprehensive screening currently defined to include: Body mass index A1C or glucose test Blood pressure Lipid panel Total cholesterol Low density lipoprotein High density lipoprotein Triglycerides. Target goal is 75%; CY 2022 rate is 94.2%	The numerator is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) glucose or HbA1c; and (4) a lipid panel. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or at another facility for which records are available to the reporting facility. The denominator includes IPF patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period. The measure excludes patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical or psychological condition and patients with a length of stay equal to or greater than 365 days or equal to or less than 3 days. Screening for Metabolic Disorders Studies show that antipsychotics increase the risk of metabolic syndrome.1 Metabolic syndrome is a cluster of conditions that occur together, including excess body fat around the waist, high blood sugar, high cholesterol, and high blood pressure, all of which increase the risk of coronary artery disease, stroke, and type 2 diabetes.	CMS/TJC	quarterly meeting/ monthly email to MHAS team	Merative CareDiscovery Quality Measures
RESTRAINTS AND SECLUSIONS										
HBIPS-2* Hours of Physical Restraint Use (per 1000 patient hours) (lower = better) FINALIZED Data Source : Merative Latest Data Month: December 2022 *Event measures are calculated by event occurrence date	0.0002 (3.5667/19944)	0.0002 (51.05/254352)	0.0003 (93.6165/269784)	0.0001		HBIPS-2 Hours of Physical Restraint Use (per 1000 patient hours) Target goal is 0.0004; CY 2022 rate is 0.0002	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	TJC	quarterly meeting/ monthly email to MHAS team	Merative CareDiscovery Quality Measures
HBIPS-3* Hours of Seclusion Use (per 1000 patient hours) (lower = better) FINALIZED Data Source : Merative Latest Data Month: December 2022 *Event measures are calculated by event occurrence date	0.0002 (4.7667/19944)	0.0002 (29.4666/167448)	0.0005 (131.1335/269784)	0.0003		HBIPS-3 Hours of Seclusion Use (per 1000 patient hours) Target goal is 0.0003; CY 2022 rate is 0.0002	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	TJC	quarterly meeting/ monthly email to MHAS team	Merative CareDiscovery Quality Measures

As of: 4/4/23

Quality Committee Follow-Up Items

Item	Date Requested	Committee Member Name	Item Requested	Individual to complete the follow up	Completion Date
	FY23				
1	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
2	9/6/2022	Carol Somersille, MD	item dated 06/06/2022 to her name and remove Holly Beeman's name under Committee Member.	Nicole Hartley	9/7/2022
3	11/7/2022	John Zoglin	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	12/12/2022
4	11/7/2022	Alyson Falwell	stroke patients evaluated and discharged from ED) performance as shared in Core Measure report during the Nov 2022 Quality Committee Meeting.	Dr. Holly Beeman	12/12/2022
5	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	2/6/2023
6	2/6/2023	Krutica Sharma, MD	Requested that we add a monthly threshold or target line to the trend chart on the Enterprise Dashboard	Dr. Holly Beeman	3/6/2023
7	2/6/2023	Krutica Sharma, MD	Request the action plan for complying with the new Joint Commission patient safety goal regarding Health Equity be shared with the committee at a future meeting.	Dr. Holly Beeman	
8	3/6/2023	Melora Simon	Deep Dive on emergency department times and throughput at a future meeting.	Dr. Meenesh Bhimani/Cheryl Reinking	
9	4/3/2023	John Zoglin	Enterprise Quality Dashboard: Dr. Beeman to work with MCH on a timely measure.	Dr. Holly Beeman	
10	4/3/2023	John Zoglin, Melora Simon, Krutica Sharma	FY24 Committee Goals: Initial committee assessment and updated FY24 Goals to be shared with QC at the May meeting by Tracy.	Tracy Folwer	
11	4/3/2023	Melora Simon	**CLOSED SESSION ITEM:** Dr. Beeman will share RCA details at the May meeting from the March Serious Safety/Red Alert Event.	Dr. Holly Beeman	

El Camino Health

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, DipACLM
Date: May 1, 2023
Subject: Voice of the Patient Feedback

Purpose:

To provide the Committee with written patient feedback that is received by the hospital.

Summary:

1. Situation: In honor of nurses week, these are comments/nominations from patients and/or families who took the time and made the effort to nominate nurses for the Daisy Award. The Daisy Award has been in place in the US and Internationally for over 20 years. ECH started its own Daisy program in 2019.

2. Authority: To provide insight into the extraordinary Nurse Daisy Award winners at ECH over the past year.

3. Background: The Daisy Award was developed and implemented by the family of Patrick Barnes. Patrick was a patient over 20 years ago at the University of Washington. He passed at the age of 32 from Idiopathic Thrombocytopenia. His family wanted to create something meaningful in his memory. They created the Daisy Foundation in his honor and began the Daisy Award program that honored the nurses who cared for him so extraordinarily during his illness.

4. Assessment: Each month, Daisy nominees are garnered from each of the units using a special nomination form. There is a box on each unit where nominations are placed by patients/families. They are gathered monthly and collated into a scoring rubric. The CNO Advisory Cabinet members vote on each nominee using a redacted approach. A winner is selected based on the person with the most number of points.

5. Other Reviews: None

6. Outcomes: A very special ceremony is completed each month on the unit where the Daisy Award is presented by the CNO. It is top secret so it is a surprise for the winner. The winner receives a special pin, customized sculpture, banner, and the whole team receives cinnamon rolls as required by the Daisy Foundation.

List of Attachments:

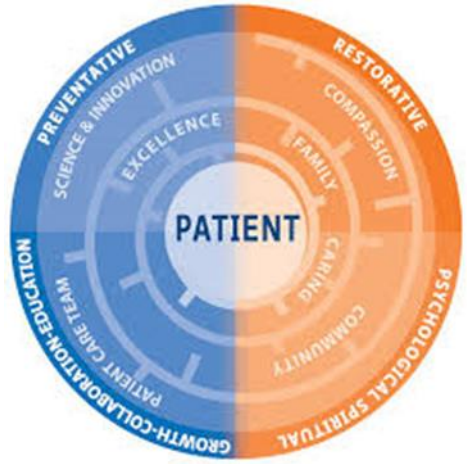
1. See attached Daisy Award Winners

Suggested Committee Discussion Questions:

1. What happens if you are nominated, but not selected to win the Daisy Award?

2. What recognition exists for other hospital employees?

El Camino Health



DAISY Winners: Voice of the Patient

April 2023

The DAISY Award®
FOR EXTRAORDINARY NURSES
HONORING NURSES INTERNATIONALLY
IN MEMORY OF J. PATRICK BARNES

May DAISY Award Winner: Luna Le PCU

As a family, we are nominating Luna for the DAISY award. She cared for our father while he was critically ill.

Luna showed compassion as she navigated his care. She was so kind, always respectful, and very thoughtful with Dad, even when he was not lucid.

She carefully explained what she was doing to both the family and to Dad in a courteous, professional manner as she went about her duties. It is clear she is a very knowledgeable and capable caregiver.

Her level of concern and compassion were evident through her interactions with our entire family. We had full confidence she would give quality care to Dad, even when we were not present. That peace of mind brought great comfort through a stressful time.

In our days spent with Dad in-patient at El Camino, Luna stands out among the nurses because of her extraordinary care and her compassionate nature. She was Dad's cheerleader.

June DAISY Award Winner: Cassandra Chu 4A Surgical

Staying in the hospital with COVID and Appendicitis was not easy, especially for one whose last hospital stay was 12 years ago giving birth. I felt lonely, uncertain, and of course ill. Cassandra brought light to me when she looked after me.

Cassandra went above and beyond when taking care of me. She balanced well on paying attention to my recovery; yet not worrying me.

After I told her, just once, about my preference on drinking hot water she brought me a cup often times without being asked. She cared about how I felt emotionally too. She gave tips on using the TV and made conversation asking about my family. I often felt like I was chatting with a friend.

Cassandra paid attend to all the details making sure I was included in all of the decisions.

All my nurses were professional but I wanted to nominate Cassandra for the DAISY award because of the way she treated me felt like a family member with love and care while I was at my weakest.

July DAISY Award Winner: Samantha Oxley 4B Oncology

Samantha quickly became my mom's favorite nurse during her two month stay at El Camino. Samantha is always incredibly friendly and smiling and truly takes her time to ensure that both the patient and family know what's going on.

My first introduction to Samantha was when she used her own money to buy my mom special treats from the Bistro downstairs just because she wanted to make sure my mom ate something.

She has always been my mom's advocate standing up for my moms rights.

She checked on my mom even on days she was not assigned to her. When my mom was confused and in intense pain, she was calling out for Samantha even though Samantha wasn't on duty.

Samantha also made sure that as a family we were taking care of ourselves.

August DAISY Award Winner: Jhouryle Concepcion MHAS

Jhouryle always goes out of her way to make sure that my stay here is as comfortable as possible.

Today she noticed that I was crying and took the time to listen to my troubles. When I didn't understand things the doctor was saying Jhouryle was nice enough to break things down in a way where I could understand better and not feel so overwhelmed.

I just feel like she cares for her patients' more than it just being her job. She really cares when you are not having the best day and tries her best to help or to make your day better in some way.

September DAISY Award Winner: Sandi Miller L&D

Sandi was one of our nurses during the delivery of my first child in August 2022. I was really disappointed to not have my mom and husband there for my son's delivery, due to COVID protocols, but Sandi stepped in as a mother figure.

When I was stubbornly sticking to my no pain medication plan but unable to sleep due to the excruciating contractions, Sandi helped me by just talking through my options and letting me know there was no judgement. That I should do what I needed to.

When pain medications didn't work, Sandi knew the anesthesiologist's schedule and ran to find him before his scheduled C-sections so I could get fast relief. She also put me in the shower and sweetly re-braided my hair.

Sandi made a really hard labor, a scary delivery, and a difficult couple of days so much better just by showing how much she cared about me.

I could not really be more grateful. She will forever be part of our family.

October DAISY Award Winner: Mark Garvey LG ED

I was riding my bike home on Winchester in the bike lane and when I came to the signal light to cross I accidentally hit a curb and I flew off my bike and landed on my knee. I was in shock laying there praying to God that I did not break anything especially because on October 1 we are leaving for a biking trip in Amsterdam and all I could think of is if there's something wrong here My husband and I are not going.

A man pulled up and rolled down his window and asked if I needed help. I didn't know what to say I think I was just lying there in so much shock and then I heard him say" I'm going to pull over , I'll be right there"! When I saw him walking over to me I went into more shock because I saw he had on medical scrubs and I thought "O my God!"

He helped me get up and I was able to walk a little bit and he said that was a good sign. Mark suggested that I could come over and get an x-ray where he worked at El Camino hospital on Pollard!

When I arrived a woman came out and when I explained what was going on she said "Oh yes" like she knew already and brought me in and when I went to sit down I had another moment of "O My God" because there was Mark standing in the doorway and said, "I'm glad you made it over we're going to take care of you"!

November DAISY Award Winner: Roksaneh Larijani Cancer Center

My mother, was diagnosed with breast cancer. As you can probably imagine, the diagnosis rocked our whole world. I don't think that I got more than a couple of hours of sleep the first several days because I was so worried and concerned. During our first appointment we were immediately greeted by Dr. S and Roksaneh.

They were both so caring and compassionate. I expressed our anxiousness and our desire to get more information about my mom's pathology results and the steps going forward. Roksaneh will probably never know how appreciative my mom and I are to her for everything that she has done and continues to do for us. She has been a god-send to us

From our first visit with her, she was patient, understanding, and compassionate. She took the time to explain to us the various options available, provided us with guidance throughout my mom's ongoing treatment. She immediately puts us at ease with her calm demeanor, and she always takes the time to answer our questions. We never feel rushed and we always leave our meetings with the knowledge and sense that she is doing everything she can. She responds to my emails and calls immediately and takes care of any issues with a bright smile and a compassionate heart.

December DAISY Award Winner: Vu Nguyen CCU

Vu was my RN for about 20 days. He brought me through the worst times of my life and I couldn't have done it without him. He pushed and shoved with suggestions how to handle the tubes in my throat and my lungs.

He was on top of everything. I was totally surprised to see him visit me on his own time. He was there for support and a sympathetic heart.

And then he was re-assigned to me. He could see how exhausted I was and how bad the infection was in my salivary gland which they didn't know how to treat. I could feel how concerned he was.

I have not made a decision where to go from here, but I wanted you to know I couldn't be where I am right now without Vu's help and empathy. He is a miracle worker. Unfortunately I may not be one of his miracle cases. But by all the stars in heaven he did all he could to help me. God bless Vu.

January DAISY Award Winner: Nikki Bryant MV ED

On Christmas Eve I brought my husband to the ED due to the urgent care being at "capacity". My husband felt horrible and that "something was really wrong" so I knew that we could not wait until the morning to be seen. The RN's in the ED were excellent from the time we checked in, and throughout our treatment. Nikki stands out as going above and beyond. After a sepsis alert was called she explained everything to my husband as it was happening, not only what was happening but why it was happening.

She had a wonderful sense of humor that was very welcomed during this stressful time. She let us know what she was doing before doing it, narrating her care in a way that made my husband feel comfortable. She paid attention to all details.

When tests were being performed on my husband I stepped out of his room and into the hallway, I was able to observe that Nikki treated ALL of her patients with the same dignity and respect that she was giving to my husband. Her passion for what she does is evident, she spoke to her patients as individuals and interacted with each patient at their level. Nikki made each patient (and family member) feel like they mattered.

February DAISY Award Winner: Nick Chow 4B Oncology

Since May 2022 I've been admitted to the hospital 9 times for infections. I've had several nurses' care for me. Nick stands out from the rest.

Almost every visit I have been in a contact isolation room. I found being in isolation limits the time the nurses would come into my room. My isolation status did not limit Nick. He would check on me several times during the day to see if I needed anything. He also would take the time to talk to me. Overall Nick would make me feel like he really cared for my wellbeing. In addition to all of my scheduled care, Nick took it upon himself to change the dressing on my back for my nephrectomy tube. I didn't have to ask for this to be done, he voluntarily changed the dressing.

Anything he told me he would do for me, he managed to do, and made sure to do before the end of his shift.

Nick let me in on the "secret menu" for the daily meals which was awesome after staying in the hospital for over three weeks and having tried all of the other menu items.

Nick made me feel like a friend more than just another patient.

El Camino Health

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: May 1, 2023
Subject: FY23 Third Quarter Board Quality Dashboard (STEEEP)

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety and experience metrics and performance through Quarter 3 of FY 2023 (unless otherwise noted).

Summary:

1. Situation: The El Camino Health Board Quality Dashboard (STEEEP) is based on the Quality Framework first elucidated in Crossing the Quality Chasm (Institute of Medicine, 2001). By striving to deliver care, which is Safe, Timely, Effective, Efficient, Equitable and Patient Centered, El Camino Health is focused on optimizing and improving our performance and processes in these six quality domains.

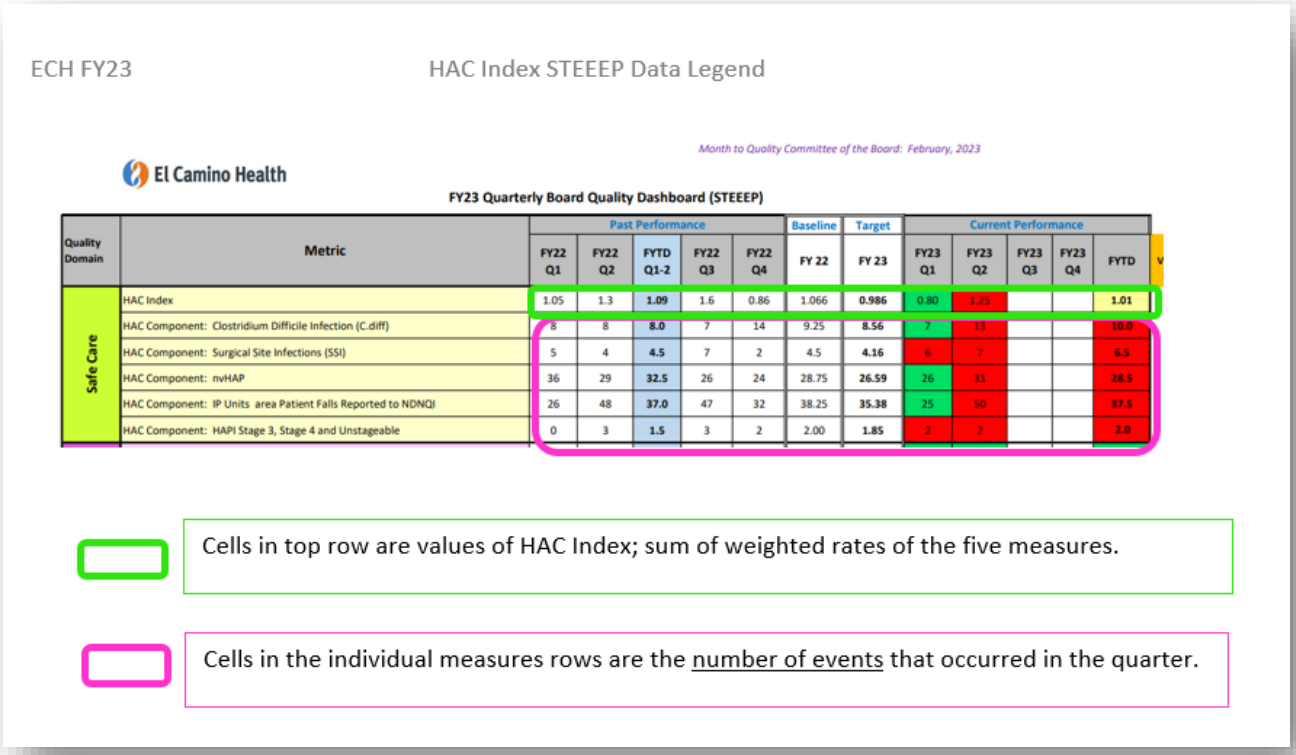
2. Authority: The Quality, Patient Care and Patient Experience Committee of the Board is responsible for the quality and safety of care provided to El Camino Health patients. This dashboard provides oversight on key quality metrics.

3. Background: At the beginning of each fiscal year, management completes an assessment to identify specific areas for quality/performance improvement. A subset of these areas are then prioritized and designated as leading indicators tracked on the Board Quality Dashboard (STEEEP), which is published once per quarter. The metrics on the STEEEP dashboard are primarily acute care measures.

4. Assessment: The second quarter results are shown in green/yellow/red performance scheme. Measures shaded in **GREEN** are at or exceeding target. Those in **YELLOW** are within 5% of the target. Measures in **RED** are off target by greater than 5%.

A. Safe Care—The Hospital Acquired Condition (HAC) metric is a weighted composite of five individual measures. The methodology for this measure is modeled after the CMS 5-Star rating methodology. Lower is better. Third quarter performance is 0.60 (favorable). HAC Index YTD is at 0.96, which is favorable to the target of 0.986. Below is a table with baseline HAC Index values from final FY22.

FY22 Baseline					
Metric	Num.	Den.	Rate	Weight	Weighted Rate
C. Difficile Infection	37	patient days	xxx	0.10	0.355
Surgical Site Infection	18	# surgeries	xxx	0.25	0.06
nvHospital Acquired Pneumonia	115	patient days	xxx	0.20	0.365
Falls	153	patient days	xxx	0.20	0.265
Hospital Acquired Pressure Injury	8	patient days	xxx	0.25	0.022
HAC Index				Sum »	1.066



ECH FY23

HAC Index STEEEP Data Legend

Month to Quality Committee of the Board: February, 2023

El Camino Health

FY23 Quarterly Board Quality Dashboard (STEEEP)

Quality Domain	Metric	Past Performance					Baseline	Target	Current Performance				
		FY22 Q1	FY22 Q2	FYTD Q1-2	FY22 Q3	FY22 Q4	FY 22	FY 23	FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	FYTD
Safe Care	HAC Index	1.05	1.3	1.09	1.6	0.86	1.066	0.986	0.80	1.25			1.01
	HAC Component: Clostridium Difficile Infection (C.diff)	8	8	8.0	7	14	9.25	8.56	7	13			10.0
	HAC Component: Surgical Site Infections (SSI)	5	4	4.5	7	2	4.5	4.16	6	7			6.5
	HAC Component: nvHAP	36	29	32.5	26	24	28.75	26.59	26	31			28.5
	HAC Component: IP Units area Patient Falls Reported to NDNQI	26	48	37.0	47	32	38.25	35.38	25	50			37.5
	HAC Component: HAPI Stage 3, Stage 4 and Unstageable	0	3	1.5	3	2	2.00	1.85	2	2			2.0

Cells in top row are values of HAC Index; sum of weighted rates of the five measures.

Cells in the individual measures rows are the number of events that occurred in the quarter.

Please see memo supporting the Enterprise Quality, Safety and Experience Dashboard for detailed description of performance and opportunities on the HAC measures.

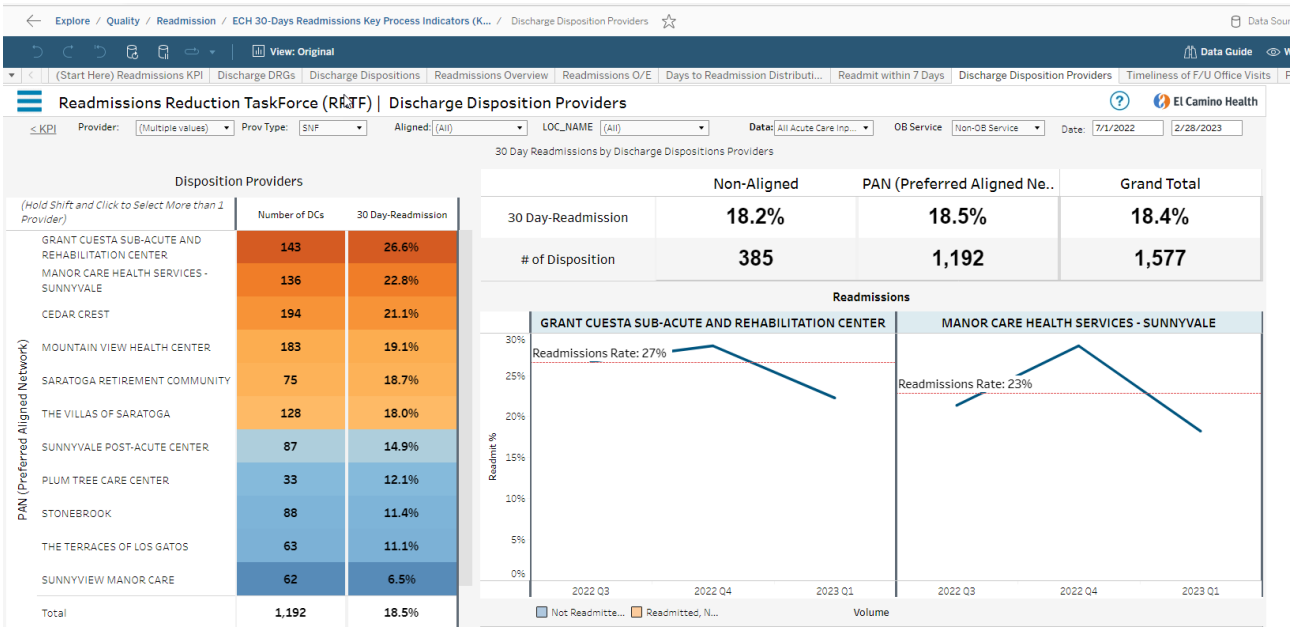
B. Timely Care

i. ED Imaging Turnaround Time. The FY23 enterprise target for imaging turnaround time in the ED is to have 84% of studies completed and read within 45 minutes. Current performance is unfavorable to target (78.2%) through March 2023. Of the 20% of studies not read within 45 minutes, several have significant delays > hours. This is not acceptable and is a safety concern. Delays in imaging are adversely impacting ED throughput and efficiency. ECH Chief Medical Officer and Chief Operating Officer are working closely with Imaging leadership to address these issues.

C. Effective

i. Risk Adjusted Readmission Index. Lower is better. Readmission Index for the third quarter of FY23 is 0.98, favorable to our target of 1.00. YTD our index through March 2023 is 1.04, unfavorable to target. The analytics and dashboards our Director of Clinical Quality Analytics has created have favorably transformed our ability to identify and focus on the key drivers of readmissions, and, track improvement as interventions are deployed. An example of how visualization of current performance helps drive improvement is our Skilled Nursing Facility (SNF) dashboard. By visualizing

readmission rates by SNF, our multidisplinary teams identify very specific interventions and partnerships to address the opportunities.



ii. Risk Adjusted Mortality Index. See Enterprise Quality Dashboard memo.

iii. Sepsis Mortality Index. See Enterprise Quality Dashboard memo.

iv. NTSV C-section Rate. See Enterprise Quality Dashboard memo.

D. Efficient

i. OP18b: Median Time from ED Arrival to ED Departure. See Enterprise Quality Dashboard memo.

E. Patient Centered. See Enterprise Quality Dashboard memo.

List of Attachments

Attachment 1—Board Quality Dashboard (STEEEP) FY23 Quarter Three.

Month to Quality Committee of the Board: May, 2023

El Camino Health

FY23 Quarterly Board Quality Dashboard (STEEEP)

Quality Domain	Metric	Past Performance				Baseline	Target	Current Performance				
		FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY 22	FY 23	FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	FYTD
Safe Care	HAC Index	1.05	1.3	1.6	0.86	1.066	**0.986**	0.80	1.28	0.60		**0.96**
	HAC Component: Clostridium Difficile Infection (C.diff)	8	8	7	14	9.25	**8.56**	7	13	9		**9.7**
	HAC Component: Surgical Site Infections (SSI)	5	4	7	2	4.5	**4.16**	6	10	1		**5.7**
	HAC Component: nvHAP	36	29	26	24	28.75	**26.59**	26	31	20		**25.7**
	HAC Component: IP Units area Patient Falls Reported to NDNQI	26	48	47	32	38.25	**35.38**	25	50	35		**36.7**
	HAC Component: HAPI Stage 3, Stage 4 and Unstageable	0	3	3	2	2.00	**1.85**	2	2	0		**1.3**
Timely	Stroke: TTITT (time to intravenous thrombolytic therapy) <= 30 min	25% (1/4)	10% (1/10)	75.0% (6/8)	0% (0/6)	28.6% (8/28)	**50%**	50% (4/8)	71.4% (5/7)	75.0% (3/4)		**63.2% (12/19)**
	Stroke: Door-to-Groin <= 90 minutes	50% (1/2)	28.6% (2/7)	50% (1/2)	25% (1/4)	33.3% (5/15)	**50%**	100% (2/2)	75.0% (3/4)	50.0% (3/6)		**66.7% (8/12)**
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)	80.35%	79.68%	82.26%	74.14%	79.01%	**84%**	78.43%	78.34%	78.28%		**78.35%**
Effective	Risk Adjusted Readmissions Index	1.05	0.96	1.12	1.06	1.05	**1.00**	1.02	1.10	0.98		**1.04**
	Risk Adjusted Mortality Index	0.99	0.92	0.99	0.85	0.94	**0.85**	1.03	1.08	1.10		**1.08**
	Risk Adjusted Sepsis Mortality Index	1.07	1.01	1.10	0.91	1.02	**0.98**	1.02	1.27	1.17		**1.15**
	PC-02 NTSV C-Section	25.8%	25.0%	24.1%	28.3%	25.80%	**23.5%**	28.8%	24.7%	n/a		**26.8%**
Efficient	OP18b: Median Time from ED Arrival to ED Departure (Enterprise)	160 min	156 min	162 min	169 min	162 min	**162 min**	176 min	168 min	169 min		**171 min**
Equitable	% Patients - Ethnicity documented	98.1%	97.9%	97.8%	97.8%	97.9%	----	97.6%	97.0%	96.6%		**97.1%**
	% Patients - Race documented	98.6%	98.5%	98.0%	98.1%	98.3%	----	97.8%	97.3%	97.3%		**97.5%**
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	82.0	80.2	81.5	79.4	80.8	**81**	79.9	78.8	76.6		**78.5**
	ED - Likelihood to Recommend (PG)	73.1	75.8	77.4	71.5	74.5	**75**	70.3	72.3	73.8		**72.1**
	MCH - HCAHPS Likelihood to Recommend	79.4	81.0	82.1	82.8	81.3	**81.5**	72.3	71.1	**83.7**		**75.3**
	ECHMN (El Camino Health Medical Network)	---	---	83.6	82.8	83.2	**83.4**	81.1	81.6	83.6		**82.2**

Updated: 4/19/23

STEEEP: Safe Care, Timely, Effective, Efficient, Equitable, Patient-Centered

Legend:

- **Green: At or exceeding target**
- **Yellow: Missed target by 5% or less**
- **Red: Missed target by > 5%**
- **White: No target**

Cell: N7
Comment: Mary_Mc:
This displays the FYTD quarterly average.

Cell: B16
Comment: Readmission Index FY23Q2: displaying 2 months only; too early to run December '22 Readmission Index. MMc

Cell: B19
Comment: PC-02 Calendar:
FY22Q4 will be submitted to CMS 11/1; then reported on next STEEEP Feb, '23. FY23Q1 will be available for reporting after 2/1/23 upon submission to CMS. MMc

Cell: B20
Comment: Arith Obs LOS/Geo Exp LOS: Sep, '22 previously reported data was based upon all inpatients instead on only Medicare Inpatients. Corrected past data; notified Sr. Leadership. MMc

Cell: B23
Comment: % Ethnicity: New for FY23; no target. Definition: Numerator: % that are populated with a valid value - excluding: Blanks, Refused to Answer or Unknown. Population: Inpatients (Patient Type = Inpatient) + ED + Outpatients Patient Type = Observation or Surgical Day Care). MMc

Cell: B24
Comment: % Race: New for FY23; no target. Definition: Numerator: % that are populated with a valid value - excluding: Blanks, Refused to Answer or Unknown. Population: Inpatients (Patient Type = Inpatient) + ED + Outpatients Patient Type = Observation or Surgical Day Care). MMc

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Shahab Dadjou, President ECHMN and Ute Burness, RN, VP of Quality, ECHMN
Date: May 1, 2023
Subject: ECHMN Quarterly Quality Report

Purpose: Provide the Board Quality Committee with a quarterly update on the status of ECHMN quality.

Summary:

1. Situation: The system Board of Directors is very interested in understanding and tracking the quality and service performance of the various components of ECHMN. It was agreed that the Board Quality Committee would review the status of quality and service performance within ECHMN on a quarterly basis.

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

3. Background: ECHMN is a wholly owned subsidiary of El Camino Hospital established as a separate corporation with its own tax ID number. It was established to develop an ambulatory care capability so that the El Camino Health continuum of care could extend beyond the traditional hospital acute care and hospital based out patient care.

4. Assessment: There are three key areas of focus for ECHMN with respect to quality and service:

A. Clinical Excellence, Dependable and Convenient Care
B. Patient Experience (Likelihood to Recommend (LTR))
C. Merit Bases Incentive Payment System (MIPS)

ECHMN has established true north pillars, one of which is quality and service. Starting June 1, 2023, ECHMN changed its quality reporting methodology. The methodology measures the performance of PCP attributed patients on six (6) clinical indicators. These measures were selected because they are important measures of health and consistent with the priorities of our health plan partners and with Centers for Medicare and Medical (CMS). ECHMN tracks the performance to targets. We have met target for three (3) clinical measures and are very close to meeting target on two (2) other measures. The blood pressure control metric is not at target and we are working on additional improvements (described in the slide deck). For the dependable and convenient domain third next available (3NA) remains unfavorable for primary care and specialty care. The attached slide deck, describes the action plan that is in place.

Likelihood to Recommend (LTR) achieved target for all clinics in February and March. The LTR is very close to target for the primary care physicians and the new Action of the Month is showing improvements in our score. The specialist and urgent care are still not on target.

MIPS is based on calendar year performance. The 2022 data was submitted in March. The preliminary score is 89.35. 89 is required to achieve exceptional status. The final score will be released from CMS in the fall of 2023. Our preliminary score of 89.35 is lower than our final score for calendar year 2021. We are currently investigating what contributed to the decline.

List of Attachments:

Power Point background material to pre-read to facilitate the discussion and use as a reference for discussion.

Suggested Committee Discussion Questions:

What additional information would be helpful for the committee to have to satisfy any concerns about quality and service in ECHMN?

El Camino Health

ECH Quality Committee Meeting
ECHMN Quality Update

May 1, 2023

Ute Burness, RN, Vice President, Quality
Shahab Dadjou, President

Clinical Excellence Domain: FYTD 23 Performance

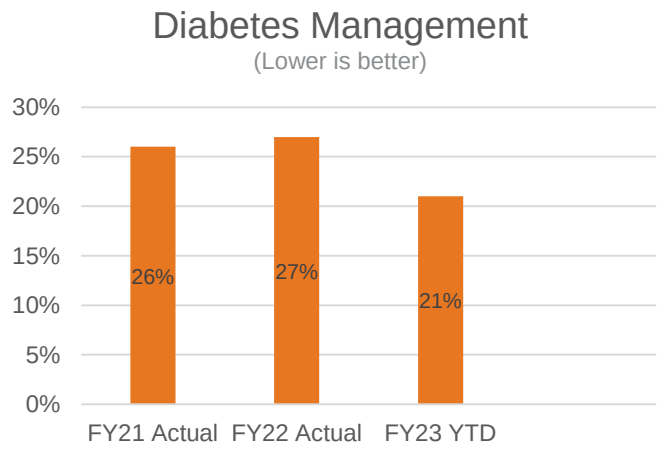
Domain	Measure	Baseline FY22	FY23 Target	FYTD thru 3/31/23
Clinical Excellence	Blood Pressure Control	60%	65%	59%
	Diabetes Management – HbA1C <9% *(Lower is better)*	24%	<20%	21%
	Breast Cancer Screening	68%	69%	76%
	Colon Cancer Screening	57%	61%	68%
	Annual Flu Vaccination	70%	71%	74%
	Medication Reconciliation	98%	98.40%	96%

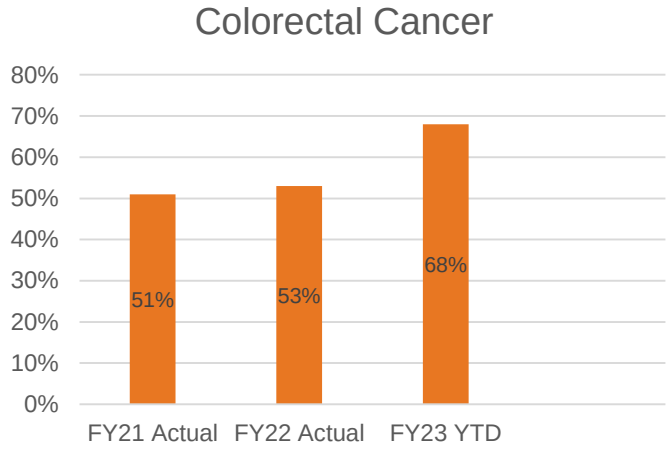
See Mitigation Plan

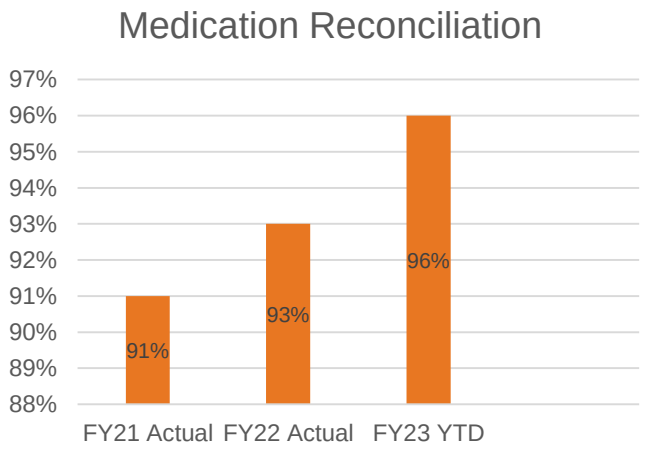
Met Target
Missed Target by < 5%
Missed Target by > 5%

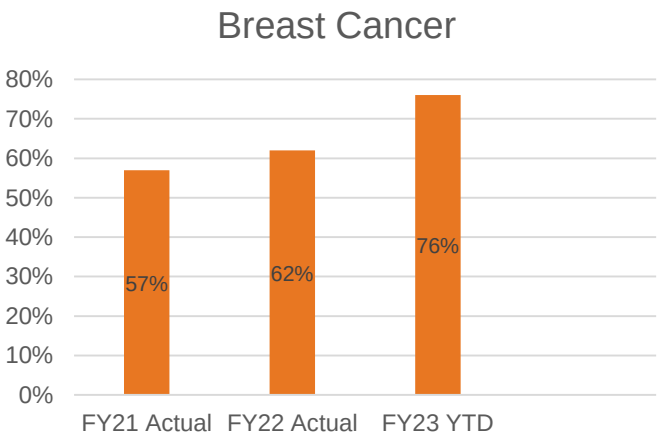
El Camino Health

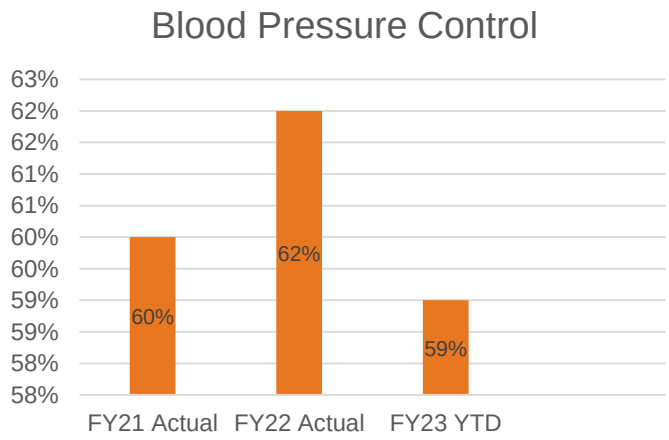
Quality Trends

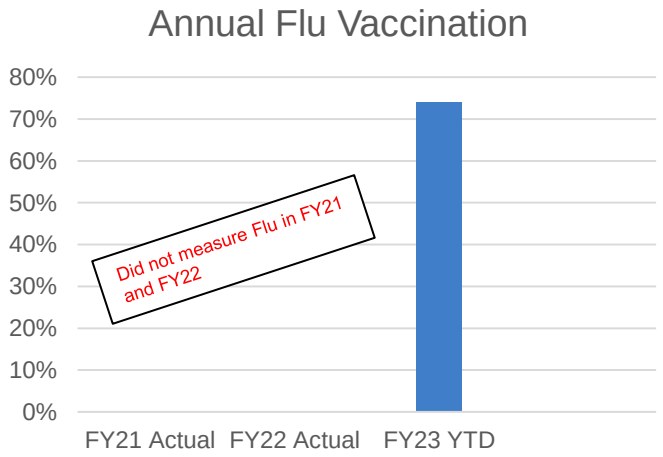












El Camino Health

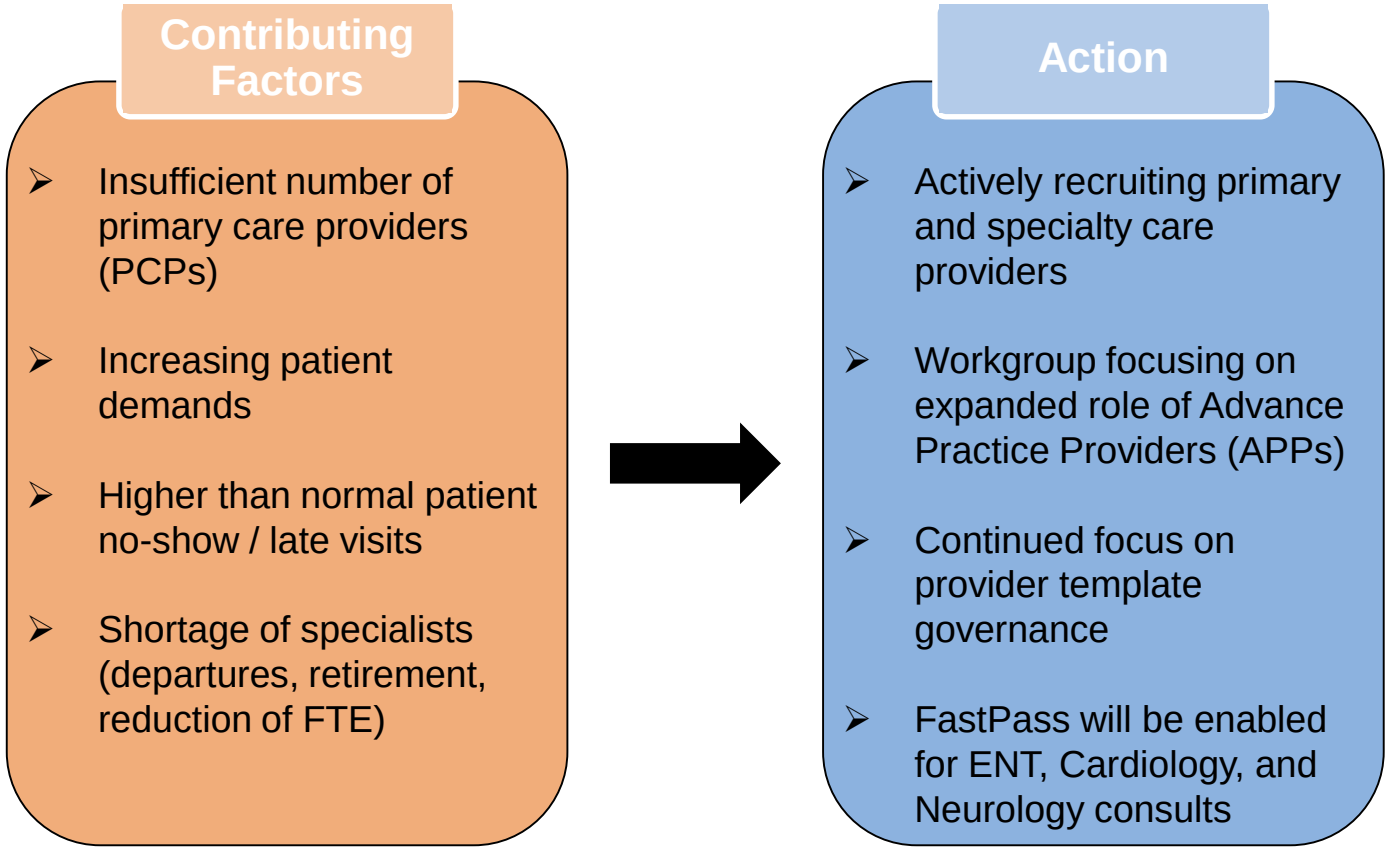
Mitigation Plan For Clinical Excellence Domain

Measure	Contributing Factors	Mitigation Plan (by June 30, 2023)
Blood Pressure Control	1. Clinic visit workflow – i.e., second blood pressure measurement, is not consistently measured 2. Multispecialty organization nuances – i.e., patients who are seen at primary care, specialty care, and urgent care 3. Data integrity	1. Standardize clinic workflow for back office 2. Implement Blood Pressure Clinics 3. Routine data audits through Epic

Dependable, Convenient and Experience Domain – March 2023

Domain	Measure	Baseline FY22	FY23 Target	March 2023
Dependable and Convenient	Access 3na for primary care (Access Third Next Available – Lower is better)	18.1 days	13.5 days	17.97
	Access 3na for specialty care (Access Third Next Available – Lower is better)	20.4 days	15.3 days	22.5
	Patient enrollment in my chart	63%	63%	70.9%
	Clinician response to patient message < 48 hours?	1.48 days	1.2 days	1.5 days
Experience	Primary Care LTR (Likelihood to Recommend)	83.2%	84.8%	82.4
	Specialty Care LTR (Likelihood to Recommend)	86.8%	87.9%	83.6
	Urgent Care LTR (Likelihood to Recommend)	78%	80.7%	76.7

Mitigation Plan for Third Next Available (3NA)



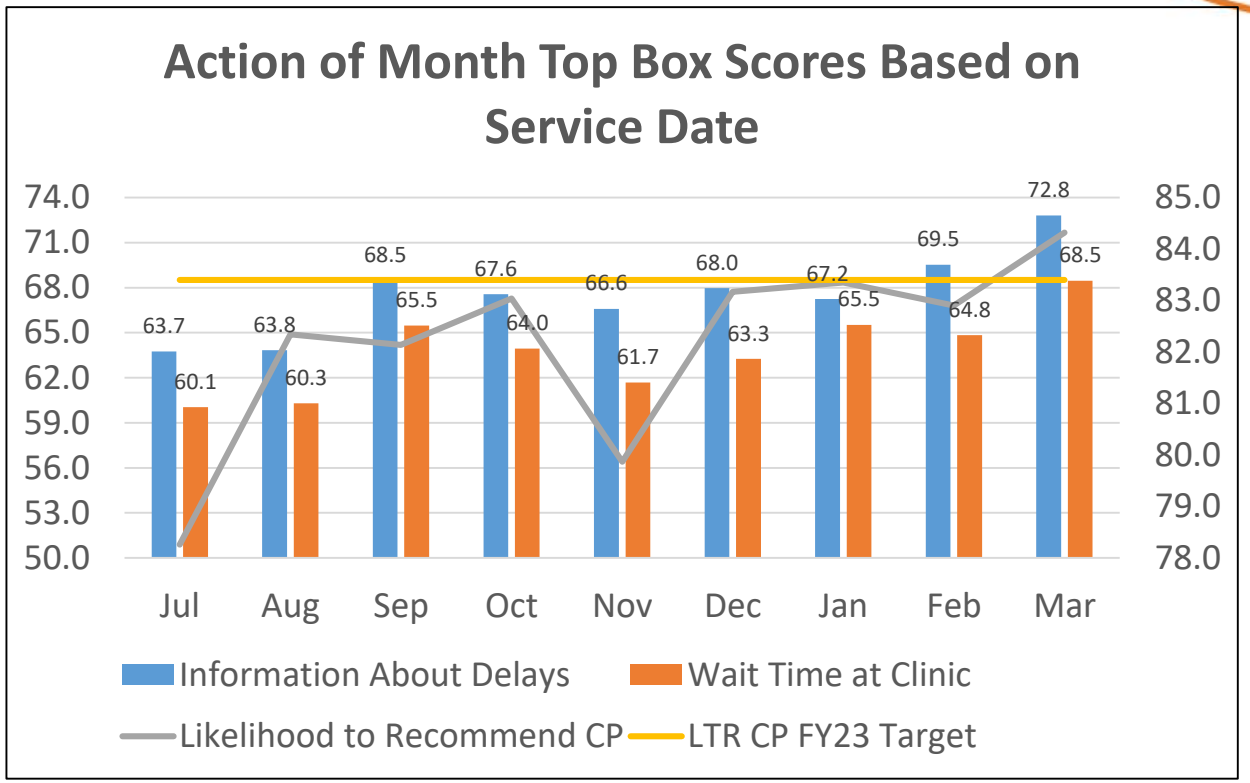
Patient Experience Domain – FYTD23

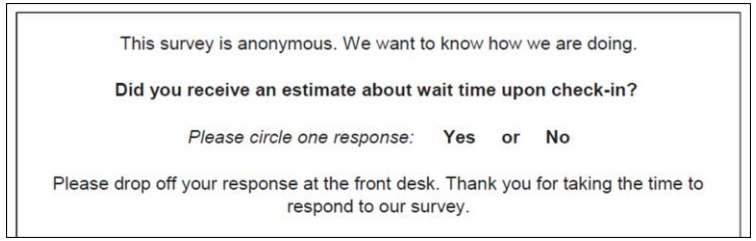
ECHMN met target for the 2nd month in a row for All Clinics

ENTERPRISE		FY23 Target Goals	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	FYTD
*ECHMN - All	LTR CP Top Box Score	83.4	78.8	82.1	82.7	82.7	79.5	82.7	83.3	84.1	83.4	82.2
	National Facilities %tile Rank		13	25	28	27	16	27	30	34	30	23
	Sample size (n)		847	820	734	848	918	963	953	957	1079	8951
ECHMN - PCP	LTR CP Top Box Score	84.8	78.5	84.9	83.0	81.1	79.4	83.9	81.4	84.7	83.6	82.3
	National Facilities %tile Rank		13	44	31	21	15	35	22	39	30	24
	Sample size (n)		428	445	389	477	431	448	445	496	560	4519
ECHMN - Specialty	LTR CP Top Box Score	87.9	82.5	79.1	83.8	86.0	83.5	82.3	86.4	85.4	83.3	83.6
	National Facilities %tile Rank		26	14	36	53	31	26	56	45	29	30
	Sample size (n)		320	297	278	279	381	373	376	356	419	3411
ECHMN - Urgent Care	LTR CP Top Box Score	80.7	67.7	76.9	76.1	80.4	66.0	79.6	81.1	77.1	83.0	76.8
	National Facilities %tile Rank		2	11	9	18	2	16	20	10	28	10
	Sample size (n)		99	78	67	92	106	142	132	105	100	1021

Patient Experience Initiative Example

- Many patient experience improvement initiatives are underway based on the voice of the patient (comments, survey responses)
- Communication about delays is a key component to the overall experience and an area for improvement. In fact, failure to inform patients about delays causes friction in a patient's journey.
- We worked with our front desk staff to provide an estimated wait time at check-in. We collected same-day surveys to confirm if patients received information about delays.
- After starting this action, the PG question on our survey "information about delays" increased significantly
- When information about delays improves, LTR CP (likelihood to recommend Care Provider) increases as well!




This survey is anonymous. We want to know how we are doing.

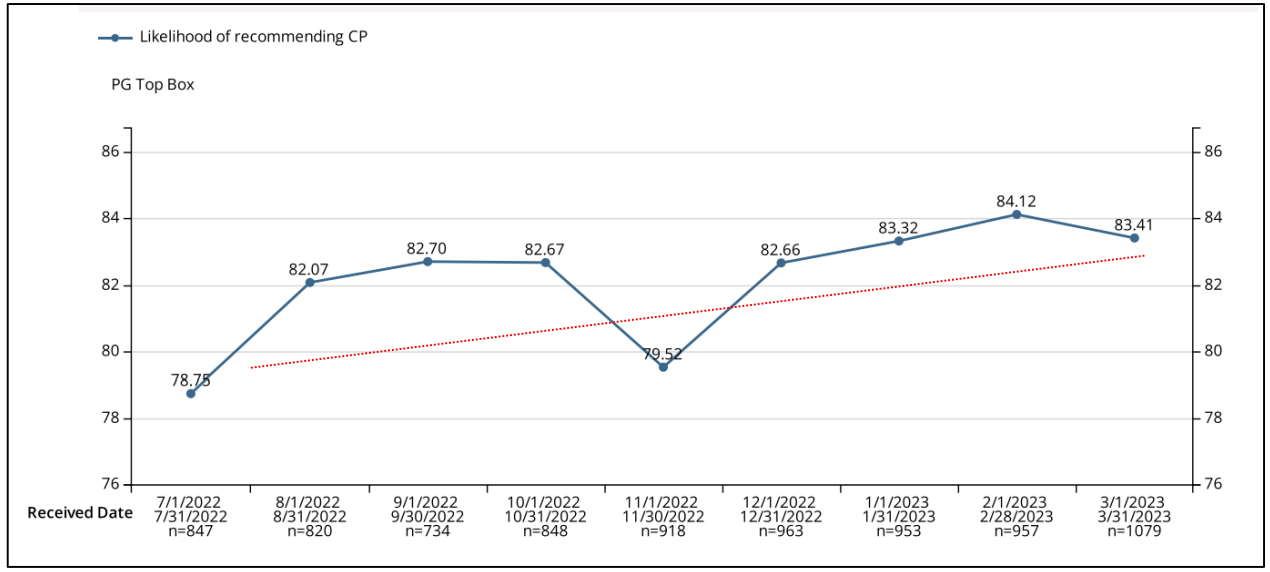
Did you receive an estimate about wait time upon check-in?

Please circle one response: **Yes or No**

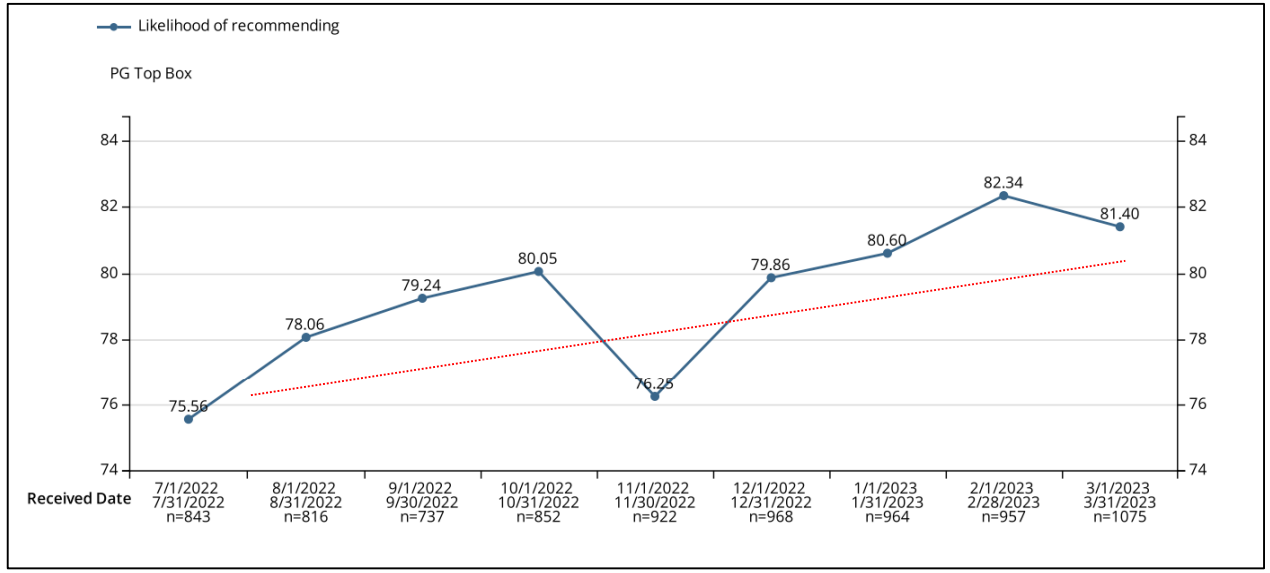
Please drop off your response at the front desk. Thank you for taking the time to respond to our survey.

Patient Experience Improvements

Dip in November due to “Triple Threat” – COVID, RSV, & Flu



Likelihood to recommend Care Provider



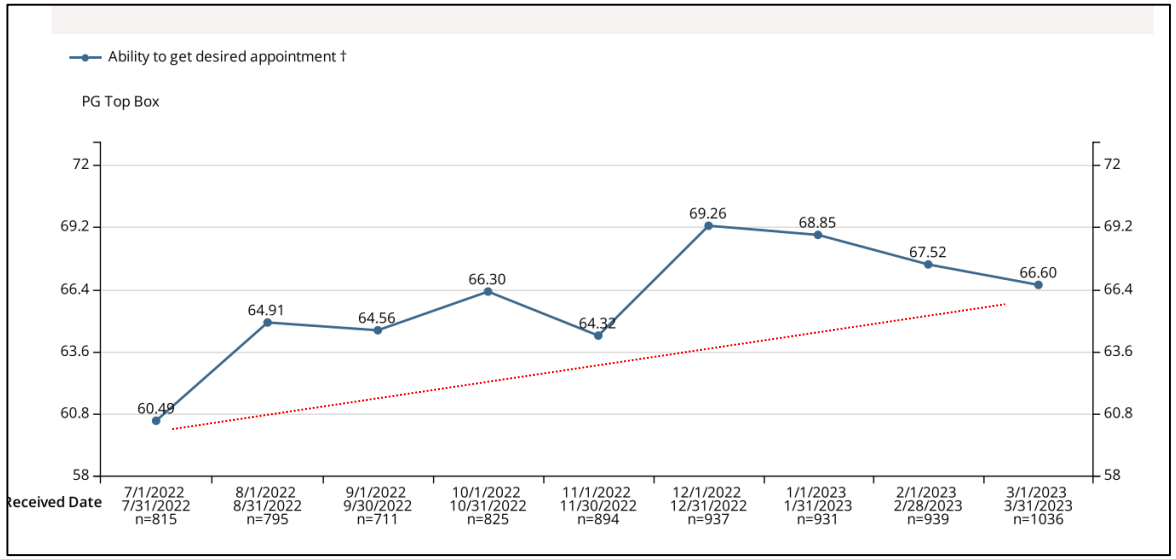
Likelihood to recommend Clinic

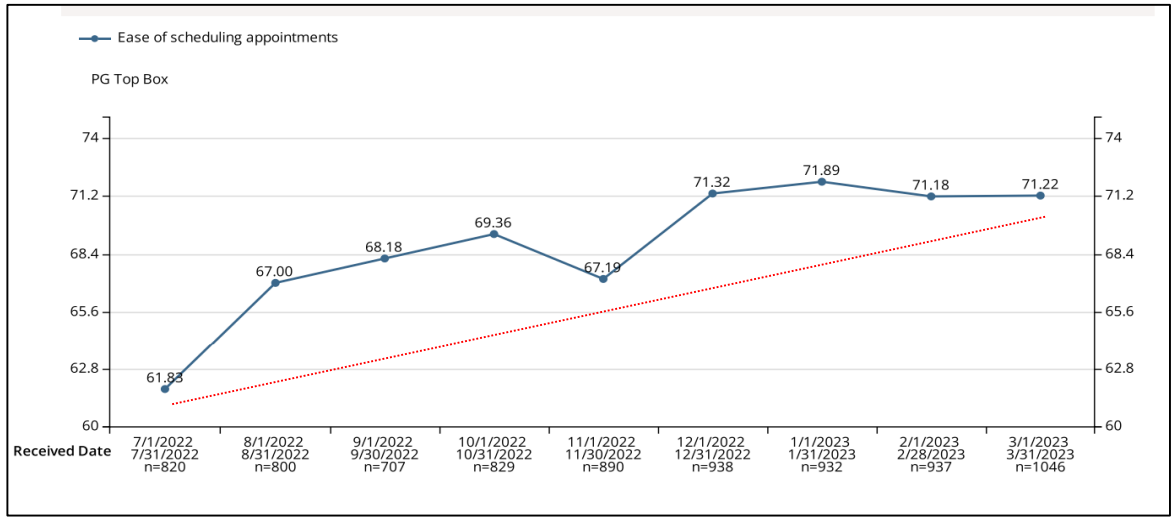
El Camino Health

Patient Experience Improvements – Access

Initiatives to improve access:

- Primary Care Template redesign
- Stabilized staffing for Front Desk, Call Center, Surgery Schedulers, and Referral Coordinators
- Pod model for Call Center scheduling
- Fast Pass





El Camino Health

El Camino Health

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: May 1, 2023
Subject: FY24 Organizational Quality Goal

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on process to identify the FY24 Organizational Quality Goal

Summary:

Situation: The organizational quality goal for FY24 will again draw focused improvement to reducing preventable patient harm events.

Assessment: Based on a cross walk of El Camino Health's performance in measures which inform both our CMS star rating and Leapfrog grades, the areas of focused improvement for FY24 will be three hospital acquired infections; Clostridium Difficile, Central Line Blood Stream Infections (CLABSI) and Catheter Associated Urinary Tract Infections (CAUTI). Additionally, we will include non-ventilator hospital acquired pneumonia (nvHAP) in the goal again for FY24. Our performance in avoiding nvHAP does not impact our external ratings, but, is the most common hospital acquired infection affecting our patients; nationally and at ECH. Non-ventilator pneumonia can be prevented.

Recommendation: HAC 2.0 is the organizational quality goal for FY24. This measure is a composite of weighted rates of 4 hospital acquired infections.

Measure	Definition Source	Rate	Weighting	Weighted Rate
CLABSI	NHSN/CMS	Per device days	TBD	aaa
CAUTI	NHSN/CMS	Per device days	TBD	bbb
C. Difficile	NHSN/CMS	Per 10,000 patient days	TBD	ccc
nvHAP	Internal "evidence based" method	Per 1,000 patient days	TBD	ddd
				SUM = HAC 2.0 Index

Attachments:

1. Article of interest
   Hospital-Acquired Pneumonia Threatens Patient Safety—Policy Makers Must Act To Confront It
2. Data review of CLABSI and CAUTI ECH trends
   CAUTI and CLABSI SIR Trends April 2023

HEALTH AFFAIRS FOREFRONT

RELATED TOPICS:
PATIENT SAFETY | HOSPITAL QUALITY | QUALITY OF CARE | SYSTEMS OF CARE | COVID-19 | VETERANS HEALTH ADMINISTRATION | PANDEMICS | ACUTE CARE | ORAL HEALTH

Hospital-Acquired Pneumonia Threatens Patient Safety—Policy Makers Must Act To Confront It

Dian L. Baker, Karen K. Giuliano, Chantal Worzala, Annie Cloke, Lu Zawistowich

APRIL 20, 2022

DOI: 10.1377/forefront.20220418.65994
<https://www.healthaffairs.org/do/10.1377/forefront.20220418.65994>

Hospital-acquired pneumonia (HAP), which includes both nonventilator-associated pneumonia (NVHAP) and ventilator-associated pneumonia (VAP), is one of the most common health care-associated infections (HAIs), constituting approximately 25 percent of HAIs <https://www.nejm.org/doi/full/10.1056/NEJMoa1801550> in acute care hospitals. Clinical guidelines and several major health systems' initiatives indicate that this widespread and costly condition can largely be prevented.

In light of the growing evidence that HAP continues to negatively impact patient outcomes, policy makers (including the Centers for Medicare and Medicaid Services [CMS]) should reinvigorate their focus on this priority problem. To date, no acute inpatient hospital quality program implemented by Medicare includes measures to prevent this condition, although CMS first considered addressing HAP through its inpatient hospital quality programs in 2008 and has started to focus on it in post-acute settings (Note 1). In this article, we:

- Review the evidence that supports the prevention of HAP as a priority for patient safety,
- Review clinical guidelines and health systems' efforts and successes aimed at HAP prevention, and
- Outline the importance of policy makers' actions on HAP prevention to improve patient safety and outcomes and potentially reduce costs, both overall and for the Medicare program.

Hospital-Acquired Pneumonia Is Common And Costly

In September 2021, the Joint Commission issued a new QuickSafety advisory —"Preventing nonventilator hospital-acquired pneumonia <https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-61/> "—which identifies NVHAP as a significant patient safety and quality issue and includes recommended actions for NVHAP prevention. This step follows the National Organization to Prevent Hospital-Acquired Pneumonia (NOHAP) <https://www.va.gov/INNOVATIONECOSYSTEM/views/solutions/national-organization.html> , a group of prominent US health care leaders, issuing a call to action to address NVHAP. According to the Joint Commission <https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-61/> , "one in every 100 hospitalized patients will be affected by NVHAP." VAP is the most commonly reported HAI among patients receiving mechanical ventilation <https://pubmed.ncbi.nlm.nih.gov/19635805/> . Furthermore, research indicates that the most common infection leading to sepsis—a potentially life-threatening condition where the body's response to an infection damages its own tissues—is pneumonia. One study <https://aacnjournals.org/ajcconline/article/29/1/9/30616/Sepsis-in-the-Context-of-Nonventilator-Hospital> estimated that 36.3 percent of patients with NVHAP developed sepsis and cites research estimating that 50 percent of sepsis cases are associated with pneumonia.

Research has also found that HAP (both NVHAP <https://pubmed.ncbi.nlm.nih.gov/31279704/> and VAP <https://pubmed.ncbi.nlm.nih.gov/33004324/>) is associated with longer hospital length-of-stay, higher overall health care costs, and increased morbidity and mortality. A 2018 analysis <https://pubmed.ncbi.nlm.nih.gov/29050905/> found that NVHAP had a mortality rate of 13 percent and, based on analysis of previous studies, contributed to longer hospital length-of-stay (13–28 days <https://pubmed.ncbi.nlm.nih.gov/29050905/>) and had associated acute care costs ranging from $28,000 to $40,000. Another analysis <https://pubmed.ncbi.nlm.nih.gov/26081180/> of previous research found that VAP has high rates of mortality (up to 17 percent), increases hospital stay (by 6 to 25 days) and leads to significant costs to the system ($12,000 to $40,000 per episode <https://pubmed.ncbi.nlm.nih.gov/26081180/>).

Together, this research demonstrates that HAP is a high-volume, high-cost HAI, making it a crucial target for CMS to include in inpatient quality programs.

COVID-19 Highlights The Need To Focus On Patient Safety And Infection Control

In addition to the growing body of research on the effects of HAP, early data on COVID-19's impacts on HAIs underscores the need for CMS to prioritize patient safety and infection control, which must include a strong focus on HAP prevention. During the COVID-19 pandemic, hospitals faced unprecedented challenges in caring for patients infected by the virus, protecting health care workers, and helping to lead vaccination efforts in their communities. The response and management of COVID-19 cases quickly became the main focus of infection prevention efforts, decreasing the time available to surveil and prevent the more traditional HAIs <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7329659/#:~:text=The%20highest%20impact%20to%20HAI,327%25%20increase%20to%20rate%20%3D%203.79> . Consistent with early studies <https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/coronavirus-disease-2019-covid19-pandemic-centrallineassociated-bloodstream-infection-clabsi-and-catheterassociated-urinary-tract-infection-cauti-the-urgent-need-to-refocus-on-hardwiring-prevention-efforts/AB369E693CE1532E9172134538 4ACAE6> , CMS and the Centers for Disease Control and Prevention (CDC) reported <https://www.nejm.org/doi/full/10.1056/NEJMp2118285> that the rate of central-line-associated bloodstream infections, catheter-associated urinary tract infections, ventilator-associated events (VAE)—which includes VAP—and methicillin-resistant *Staphylococcus aureus* bacterium infections had increased in US hospitals since the

beginning of the pandemic. This points to the need to continue to focus on preventable HAIs and to include HAP.

Policy Makers Have Yet To Include HAP In Acute Inpatient Hospital Prevention Efforts

Congress and CMS have acted to reduce rates of certain hospital-acquired infections through the Hospital-Acquired Conditions (HACs) and Present on Admission <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/wPOA-Fact-Sheet.pdf> (POA) policy and the Hospital-Acquired Condition Reduction Program <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program> (HACRP), which address HAIs that are preventable and high volume and/or high cost. Yet, HAP has not been included in these programs.

CMS first considered adding a measure on VAP to the HAC POA program in the FY 2008 Inpatient Prospective Payment Systems proposed rule <https://www.federalregister.gov/documents/2007/08/22/07-3820/medicare-program-changes-to-the-hospital-inpatient-prospective-payment-systems-and-fiscal-year-2008> , but the agency did not finalize this proposal, citing concerns about coding, diagnosability, and preventability. In subsequent regulatory decision making on HAIs, CMS included catheter-associate urinary tract infections, Methicillin-resistant Staphylococcus aureus (MRSA), and select surgical site infections in the HACRP, despite a significantly lower volume of many of these HAIs as compared to HAP. In adding MRSA, CMS specifically noted that HAIs "must be reasonably—and not completely—preventable for inclusion in the HACRP." These conditions offer examples of how addressing HAP through acute inpatient hospital quality programs would be consistent with the agency's previous efforts and could incentivize actions to reduce this prevalent, costly, and largely preventable complication.

Policy makers have taken some steps to address VAP in other settings or programs, but only on a short-term or limited basis.

- In 2011, CMS and the Center for Medicare and Medicaid Innovation's Partnership for Patients <https://innovation.cms.gov/innovation-models/partnership-for-patients> Hospital Engagement Network led a collaborative national patient safety initiative to address a broad range of hospital-acquired conditions, including VAEs such as VAP (Note 2). The Partnership for Patients has since ended.

- In FY 2015, CMS included a VAE measure in the Long-Term Care Hospital quality reporting program <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information> . However, the measure was removed in FY 2019 as part of CMS's Meaningful Measures Initiative.
- More recently, CMS's FY 2022 Skilled Nursing Facility Prospective Payment System Final Rule <https://www.federalregister.gov/public-inspection/current> added a measure on health care-associated infections requiring hospitalization, which includes pneumonia, to the skilled nursing facility quality program.

Most recently, CMS and the CDC highlighted the need to focus on patient safety <https://www.nejm.org/doi/full/10.1056/NEJMp2118285> as a key part of building a resilient health care system in response to increased rates of health care-associated infections during the COVID-19 pandemic. HAP prevention must be included as a key part of this effort. Including HAP is consistent with CMS's inclusion of VAEs as a priority area and measure need for the HACRP in 2019 <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/2019-CMS-Measurement-Priorities-and-Needs.pdf> , 2020 <https://www.cms.gov/files/document/cms-measurement-priorities-and-needs.pdf> , and 2021 <https://www.cms.gov/files/document/2021-muc-list-program-specific-measure-needs-and-priorities.pdf> . Despite prioritizing VAEs, however, CMS has not proposed any new policy to address HAP in the inpatient setting.

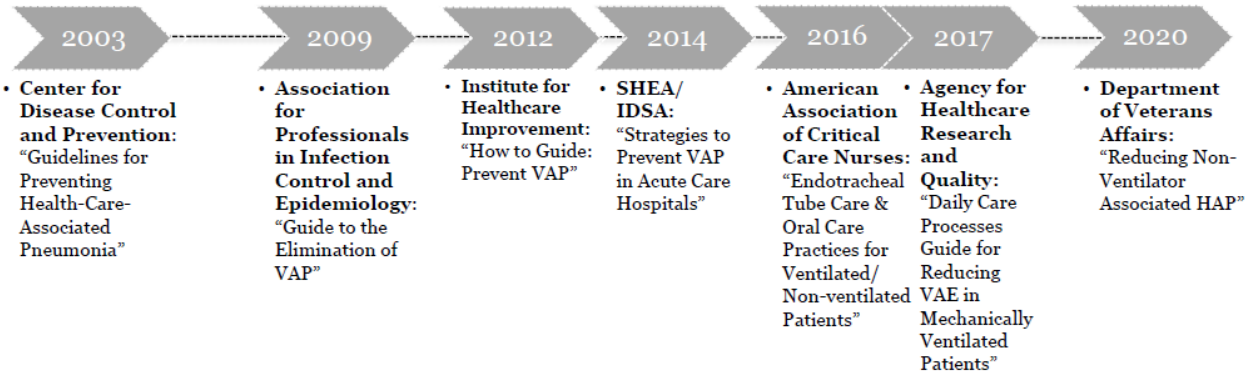
Clinical Guidelines And Health System Initiatives Show HAP May Be Prevented

While stakeholders have raised concerns about the ability to diagnose and prevent HAP, the recent proliferation of guidelines for HAP prevention, coupled with successful reductions in HAP at major health systems, demonstrates that both issues can be addressed. In addition, research is underway <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2753253> to allow for easy and efficient electronic health record data extraction to identify NVHAP.

Clinical guidelines and recommendations for the prevention of HAP date back to 2003 and have been issued by several federal agencies, including the CDC <https://www.cdc.gov/infectioncontrol/guidelines/pneumonia/index.html> , the Agency for Healthcare Research and Quality <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/hais/tools/mvp/modules/technical/daily-care-processes-guide.pdf> (AHRQ), and the Department of Veterans Affairs (VA). Professional health care and infectious disease

societies have also issued similar guidelines, indicating that implementation of HAP programs can reduce harm and improve patient outcomes (see exhibit 1).

Exhibit 1: Timeline of HAP prevention guidelines



Sources: CapView Strategies Analysis. (Links to the additional guidelines in this exhibit are listed in Note 3.)

In addition to clinical guidelines, several health system initiatives have shown promising results—especially in preventing NVHAP. Studies examining NVHAP prevention efforts in integrated health systems such as Kaiser Permanent Northern California, Sutter Health, and the Veterans Health Administration (VHA) show that systemwide initiatives can effectively reduce the incidence of NVHAP and underscore that prevention efforts can work. Kaiser Permanente Northern California implemented an initiative to prevent NVHAP for high-risk patients and decreased NVHAP rates <https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/abs/successful-program-preventing-nonventilator-hospitalacquired-pneumonia-in-a-large-hospital-system/E7EFB3B734B3EB3FFDBD07C83DE3250D> from 5.9 per 1,000 admissions to 1.8 per 1,000 admissions, or 69 percent, between 2012 and 2018. The same study also found a 73 percent reduction in NVHAP mortality rates (1.1 to 0.3 per 1,000 admission) and a reduction in broad-spectrum antibiotic use after the intervention was implemented. Sutter Health's NVHAP prevention initiative led to a significant reduction in the incidence of NVHAP, with results sustained over four years. A study found that Sutter Health's protocol, of a daily oral care regimen, led to a 23–46 percent reduction in the incidence of NVHAP <https://www.chpso.org/sites/main/files/baker_quinn_ewan_giuliano_2018_sustain_quality_oral_care__nv_hap_j_nsg_care_quality_doi10.1097.pdf> between 2013 and

2016. A VHA initiative <https://www.va.gov/INNOVATIONECOSYSTEM/views/solutions/happen.html> known as HAPPEN, which aimed to reduce incidence of NVHAP by implementing an oral care regime, started in one facility in 2016 and has been expanded to all VA hospitals nationally.

These efforts show that systems that have applied a consistent diagnostic method and prevention protocol have successfully reduced their incidence of NVHAP and provide templates that can be replicated within other hospital systems. As such, policy makers should not allow the lack of a gold standard for diagnosing HAP to impede their needed action.

Policy Maker Action Is Needed To Address HAP, Improve Medicare Beneficiary Outcomes, And Reduce Program Costs

As emphasized recently by CMS and the CDC <https://www.nejm.org/doi/full/10.1056/NEJMp2118285> , prioritizing patient safety and infection control will be critical components of any strategy to rebuild and strengthen public health after COVID-19. As evidence demonstrating the benefits of addressing HAP—with a significant focus on NVHAP—grows, stakeholder calls to focus on HAP prevention have also increased, most notably through the NOHAP call to action.

Given the growing body of research and evidence demonstrating the prevalence and impacts of pneumonia, Congress and CMS should reinvigorate their focus on this priority problem and take action on HAP prevention, either within existing quality programs or through innovative efforts. A number of policy levers are available to address this serious gap in patient safety. In the near term, policy makers could incorporate an existing HAP-related measure into Medicare hospital or other quality programs—or into other reforms to programs promoting quality and safety in Medicare. Policy makers also could facilitate collaborative efforts to build on and increase adoption of the successful models demonstrated through initiatives at the VHA and other health systems. In the long term, there may be opportunities to develop more accurate quality measures for the prevention of HAP, or to use the Quality Payment Program or the Center for Medicare and Medicaid Innovation's authority to improve quality of care and patient safety.

Among the many lessons learned from the COVID-19 pandemic is the need to reprioritize infection control within the health system. Growing evidence demonstrates that preventing HAP is an imperative step toward accomplishing this goal, and that HAP

must be addressed by policy makers to protect patient safety and strengthen the health system for the future.

Note 1

Measures that address the treatment of individuals being treated for pneumonia as their primary condition have been used, but no measures to incentivize the prevention of pneumonia acquired while in the hospital after being admitted for another condition have been incorporated into hospital quality programs.

Note 2

The interim evaluation <https://downloads.cms.gov/files/cmmi/pfp-interimevalrpt.pdf> of Partnership for Patients conducted in 2015 found that national rates of inpatient harm, including VAE/VAP, markedly improved during the time the model was operating, but did not find differences in the rate of improvement across hospitals that did and did not participate. However, the evaluation found that certain project activities, such as peer-to-peer networking, skills training, and virtual consultation or coaching, were "associated with a greater likelihood of a hospital implementing operational changes targeting harm reduction compared to those that did not participate in these activities." In addition, the AHRQ <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/hacreport-2019.pdf> found overall reductions in HAIs from 2014 to 2017.

Note 3

- American Association of Critical Care Nurses: Endotracheal Tube Care & Oral Care Practices for Ventilated/ Non-ventilated Patients <https://www.aacn.org/docs/Photos/Procedure-04-dab15t1l.pdf>

Authors' Note

Stryker provided funding to support the research and analysis of this project.

Article Metrics

<https://www.altmetric.com/details.php?domain=www.healthaffairs.org&citation_id=127226027>

Related

CONTENT

Hospitals

TOPICS

Patient Safety
Hospital Quality
Quality Of Care
Systems Of Care
COVID-19
Veterans Health Administration
Pandemics
Acute Care
Oral Health

Cite As

"Hospital-Acquired Pneumonia Threatens Patient Safety—Policy Makers Must Act To Confront It", Health Affairs Forefront, April 20, 2022.

DOI: 10.1377/forefront.20220418.65994

El Camino Health®

FY 2022 CAUTI and CLABSI Data Review

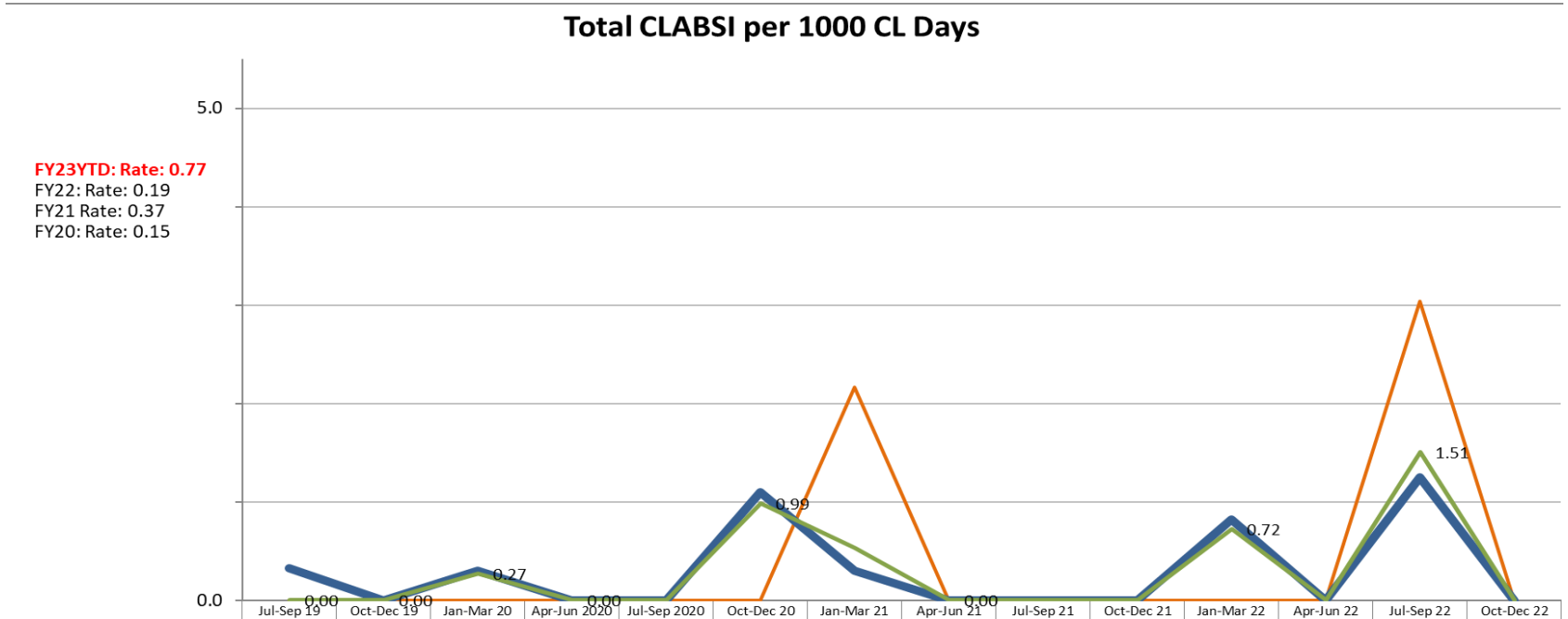
NHSN SUR: Standard Utilization Ratio

NHSN SIR: Standardized Infection Ratio

Catherine Nalesnik, RN, BSN, CIC

Director Infection Prevention

Catheter Acquired Blood Stream Infections



	Jul-Sep 19	Oct-Dec 19	Jan-Mar 20	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 20	Jan-Mar 21	Apr-Jun 21	Jul-Sep 21	Oct-Dec 21	Jan-Mar 22	Apr-Jun 22	Jul-Sep 22	Oct-Dec 22
LG Total BSI per 1000 CL Days	0.00	0.00	0.00	0.00	0.00	0.00	2.16	0.00	0.00	0.00	0.00	0.00	3.04	0.00
MV Total BSI per 1000 CL Days	0.33	0.00	0.30	0.00	0.00	1.10	0.30	0.00	0.00	0.00	0.83	0.00	1.25	0.00
Ent Total BSI per 1000 CL Days	0.00	0.00	0.27	0.00	0.00	0.99	0.53	0.00	0.00	0.00	0.72	0.00	1.51	0.00
LG Total BSI	0	0	0	0	0	0	1	0	0	0	0	0	2	0
MV Total BSI	1	0	1	0	0	4	1	0	0	0	3	0	5	0
Ent BSI	1	0	1	0	0	4	2	0	0	0	3	0	7	0
MV Total CL Days	3052	2931	3341	2652	3803	3641	3307	3213	3375	3356	3636	3580	3987	3620
LG Total CL Days	350	457	368	499	428	413	462	578	354	392	503	464	658	858
Ent Total CL Days	3402	3388	3709	3151	4231	4054	3769	3791	3729	3748	4139	4044	4645	4478

FY 2020	FY 2021	FY 2022	FY 2023 to date
Total: 2 **MV: 2** **LG: 0**	**Total: 6** **MV: 5** **LG: 1**	**Total: 4** **MV: 3** **LG: 0** **MV-NICU: 1**	**Total: 8** **MV: 5** **LG: 3** **MV-NICU: 0**

National Healthcare Safety Network (NHSN)
FY2022 Central Line Device Days
Standard Utilization Ratio (SUR)

Central Line SUR GOAL: SIR ≤ 1.0		National SUR comparison Calendar Year	California SUR comparison Calendar Year
Mountain View			
Central Line SUR	**1.2**	2020: 0.90 2021: 0.90	2020: 0.96 2021: 0.96
Central line days	14,469		
NHSN predicted CVL days	11,955		
Los Gatos			
Central Line SUR	**0.87**		
Central line days	1,760		
NHSN predicted CVL days	2,021		

CLABSI Goal: SIR < 0.50
National Healthcare Safety Network (NHSN) Standardized Infection Ratio (SIR)

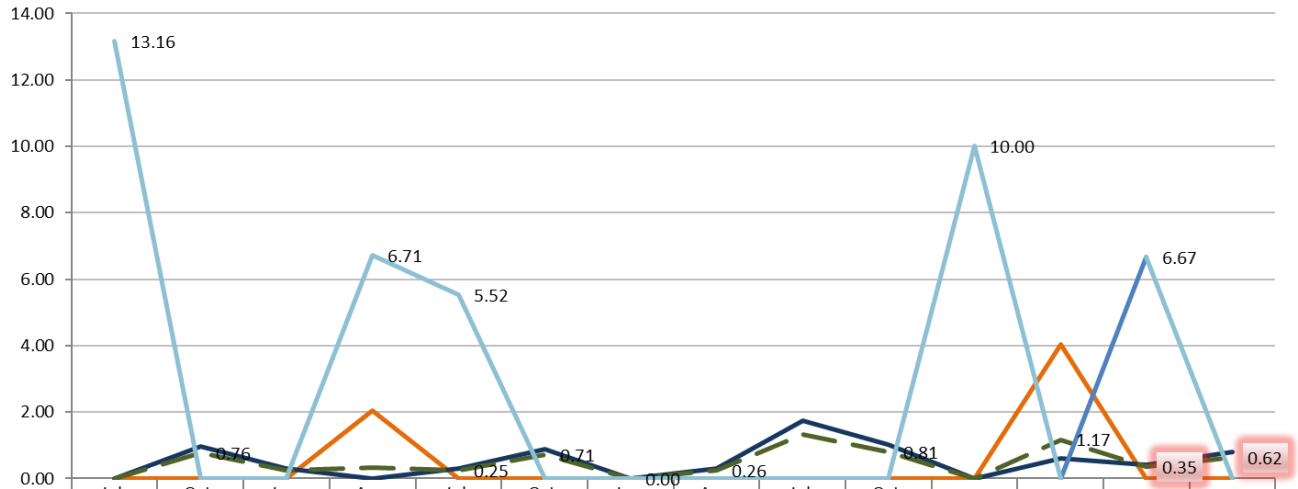
CLABSI GOAL: NHSN SIR ≤ 0.50				
	FY 2023 SIR *7/22-12/22	FY 2022 SIR	FY 2021 SIR	FY 2020 SIR
Mountain View	**0.809**	**0.35**	**0.43**	**0.20**
CLABSI cases **predicted to meet SIR: 5*	5	4	5	2
Los Gatos	**1.898**	**0.0**	**0.81**	**0.0**
CLABSI cases **predicted to meet SIR: 1*	2	0	1	0

Calendar year	National SIR	California SIR
2020	0.86	0.86
2021	0.92	0.91

Catheter Acquired Urinary Tract Infections-

Enterprise Rate
FY23YTD Rate: 0.48
FY22 Rate: 0.81
FY21 Rate: 0.30
FY20 Rate: 0.34

Rehab L13:
FY23YTD: 3.18
FY22 Rate: 1.68
FY21 Rate: 1.82



	Jul-Sep 2019	Oct-Dec 2019	Jan-Mar. 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021	Jan-Mar22	Apr-Jun 22	Jul-Sep 22	Oct-Dec 22
LG-CAUTIs per 1000 Acute Foley Catheter Days	0.00	0.00	0.00	2.04	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4.04	0.00	0.00
MV-CAUTIs per 1000 Acute Foley Catheter Days	0.00	0.96	0.30	0.00	0.31	0.89	0.00	0.32	1.73	1.01	0.00	0.60	0.42	0.81
Ent-CAUTIs Rate	0.00	0.76	0.25	0.32	0.25	0.71	0.00	0.26	1.32	0.81	0.00	1.17	0.35	0.62
Rehab CAUTIs per 1000 Cath Days	13.16	0.00	0.00	6.71	5.52	0.00	0.00	0.00	0.00	0.00	10.00	0.00	6.67	0.00
LG- # Catheter Acquired UTIs	0	0	0	1	0	0	0	0	0	0	0	3	0	0
MV- # Catheter Acquired UTIs	0	3	1	0	1	3	0	1	5	3	0	2	2	3
# Rehab Catheter Acquired UTIs	1	0	0	1	1	0	0	0	0	0	1	0	1	0
LG- # Acute Foley Catheter Days	648	743	536	490	633	721	770	649	752	620	839	742	787	955
MV- # Acute Foley Catheter Days	3055	3132	3371	2496	3247	3352	3402	3160	2888	2957	3400	3318	4744	3682
Ent- # Acute Foley Catheter Days	3779	3930	4015	3135	4061	4229	4286	3899	3790	3713	4339	4270	5681	4801
# Rehab Foley Catheter Days	76	55	108	149	181	156	114	90	150	136	100	210	150	164

FY 2020	FY 2021	FY 2022	FY 2023 to date
Total: 7 MV: 4 LG: 1 Rehab: 2	**Total: 6** MV: 5 LG: 0 Rehab: 1	**Total: 14** MV: 10 LG: 3 Rehab: 1	**Total:10** MV: 8 LG:0 Rehab:2

National Healthcare Safety Network (NHSN)
FY2022 Urinary Catheter Device Days
Standard Utilization Ratio (SUR)

Urinary Catheter Device SUR GOAL: SIR ≤ 1.0		National SUR comparison Calendar Year	California SUR comparison Calendar Year
Mountain View			
Urinary Catheter device SUR	**0.6**	2020: 0.8 2021: 0.9	2020: 0.8 2021: 0.9
Urinary catheter days	11,866		
NHSN predicted Urinary catheter days	18,060		
Los Gatos			
Urinary Catheter device SUR	**0.9**		
Urinary catheter days	2976		
NHSN predicted Urinary catheter days	3,256		

CAUTI Goal: SIR < 0.75
National Healthcare Safety Network (NHSN)
Standardized Infection Ratio (SIR)

CAUTI GOAL: NHSN SIR ≤ 0.75				
	FY2023 SIR *Jul. 22-Dec. 22	FY 2022 SIR	FY 2021 SIR	FY 2020 SIR
Mountain View	**0.797**	**1.0**	**0.47**	**0.42**
CAUTI cases ***predicted to meet SIR: 7**	5	10	5	4
Los Gatos	0.0	**1.6**	**0.0**	**0.68**
CAUTI cases ***predicted to meet SIR: 1**	0	3	0	1
Los Gatos Rehab	Not available	0.6	0.68	**1.9**
CAUTI cases ***predicted to meet SIR: 1**	1	1	1	2

Calendar Year	National SIR	California SIR
2020	0.75	0.89
2021	0.79	0.88