El Camino Health

AGENDA

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

Monday, February 1, 2021 – 5:30pm

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

PURSUANT TO STATE OF CALIFORNIA EXECUTIVE ORDER N-29-20 DATED MARCH 18, 2020, El CAMINO HEALTH **WILL NOT BE PROVIDING A PHYSICAL LOCATION FOR THIS MEETING**. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 760-083-0558#. No participant code. Just press #.

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Julie Kliger, Quality Committee Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 5:32 – 5:33**
3.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:34**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (12/07/2020) ***Information*** b. Progress Against FY21 Committee Goals c. FY21 Enterprise Quality Dashboard d. Report on Board Actions e. Quality Committee Follow-Up Tracking f. Article of Interest			
4.	**CHAIR'S REPORT**	Julie Kliger, Quality Committee Chair		**information 5:34 – 5:39**
5.	**PATIENT STORY** **ATTACHMENT 5**	Cheryl Reinking, RN, CNO		**discussion 5:39 – 5:44**
6.	**EL CAMINO HEALTH MEDICAL NETWORK REPORT** **ATTACHMENT 6**	Mark Adams, MD, CMO		**discussion 5:44 – 6:04**
7.	**QUARTERLY BOARD QUALITY DASHBOARD REVIEW** **ATTACHMENT 7**	Mark Adams, MD, CMO		**discussion 6:04 – 6:14**
8.	**HEALTH EQUITY** **ATTACHMENT 8**	Mark Adams, MD, CMO		**discussion 6:14 – 6:29**
9.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information 6:29 – 6:32**
10.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 6:32 – 6:33**

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 6:33 – 6:34**
12.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair		**motion required 6:34 – 6:35**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (12/07/2020) ***Information*** b. Quality Council Minutes			
13.	*Health and Safety Code Section 32155* **Q2 FY21 QUALITY AND SAFETY REVIEW**	Mark Adams, MD, CMO		**motion required 6:35 – 6:50**
14.	*Health and Safety Code Section 32155* **MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, CMO		**motion required 6:50 – 7:00**
15.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Serious Safety Event/Red Alert Report	Mark Adams, MD, CMO		**discussion 7:00 – 7:05**
16.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:05 – 7:06**
17.	**RECONVENE OPEN SESSION/ REPORT OUT**	Julie Kliger, Quality Committee Chair		**information 7:06 – 7:07**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
18.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 7:07 – 7:12**
19.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:12 – 7:13**

El Camino Health

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, December 7, 2020
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent
Julie Kliger, Chair**	
George O. Ting, MD, Vice Chair**	
Alyson Falwell**	
Melora Simon**	
Krutica Sharma, MD**	
Jack Po, MD**	
Terrigal Burn, MD**	
Michael Kan, MD	
Apurva Marfatia, MD**	**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 5:30pm by Chair Kliger. A verbal roll call was taken. Michael Kan, MD, joined the meeting in person during Agenda Item #5. All other members were present at roll call and participated telephonically. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Chair Kliger asked if any member of the Committee or the public wished to remove an item from the consent calendar. Chair Kliger pulled Agenda Item 3c for discussion. She suggested waiting a year to see a trend. Otherwise, the committee will frequently be questioning the graph. Dr. Adams stated that the graph is in a true state for the data that has been produced thus far. He stated that by January, there will be 12 months of data. Ms. Falwell pulled Agenda Item 3d for discussion. She was curious to understand how the Committee may impact the equity metric and how they may impact some of the data in OB trauma. Dr. Adams stated that there is a committee currently working on a charter that could serve as a sounding board for some of those questions. **Motion:** To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (10/05/2020); For information: (b) Progress Against FY21 Committee Goals, (c) FY21 Enterprise Quality Dashboard, (d) Hospital Update, (e) Report on Board Actions, (f) Quality Committee Follow-Up Tracking, (g) CDI Dashboard, (h) Core Measures and (i) Article of Interest. **Movant:** Ting **Second:** Sharma **Ayes:** Burn, Falwell, Kliger, Marfatia, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** Kan **Recused:** None	***Consent Calendar approved***

4. CHAIR'S REPORT	Chair Kliger reported on the Chair's Report. She went over what occurred at the last board meeting.	
5. PATIENT STORY	Cheryl Reinking, RN, CNO, presented a Patient Story. She stated that this comment was from an iSafe report related to patient care. A patient had reported to her nurse that she wanted to speak to the nursing supervisor. The patient expressed that everyone had shown compassion towards her except for two people: the radiology technician and the physician. She stated that the physician seemed angry and abrupt and that the radiology technician was dismissive and not very sympathetic. The manager of the unit where the patient was staying spoke to her right away and performed a "service recovery" to make the patient feel safe. Ms. Reinking stated that management had also followed up with the technician about the complaint and educated him/her on the WeCare standards as it is essential to patient care. In addition, Ms. Reinking stated that when a patient expresses concerns about a physician, it is processed through the grievance process. A letter and a phone call is made to the physician about the complaint. Dr. Mallur stated that the physician will also draft a letter to the patient. If there is a repeated behavioral issue, two of the medical staff leaders would sit down with the physician and sometimes it will be escalated to the leadership council. In this situation, Dr. Mallur stated he had spoken to the patient. In response to a committee member's question, Dr. Adams stated that the patient came in with vomiting, nausea, and constipation complaints and that a CT scan was a medical decision made by a physician and he cannot comment as to if that was the right or wrong decision. He stated that every physician will have differences of opinion in regards to patient care.	
6. READMISSION DASHBOARD	Mark Adams, MD, CMO, presented the Readmission Dashboard. He stated that the seven diagnostic groups as presented in the materials are the ones that tend to frequently occur and it just so happens to coincide with the readmission penalty program. Dr. Adams stated that it does have an impact on the hospital because of the penalty program. The dashboards have been showing overall improvement consistently throughout several years. Nevertheless, the penalty would interfere with future Medicare payments. 80% of hospitals across the country get a penalty. The maximum penalty is 3% and the best a hospital could get is 0 (no penalty). In response to committee members' questions, Dr. Adams stated that when a hospital gets penalized, it affects all Medicare business. Dr. Adams stated that there are a number of interventions that can be done to try to minimize those readmissions and management is working with the staff to try and decrease those incidents.	
7. PSI REPORT	Dr. Adams presented the PSI Report. Dr. Adams stated that the PSI is mostly in good standing. The iatrogenic pneumothorax can happen when there are needles that are inserted in patients for biopsies in the thorax. Management is still working with the OB goup to try to mitigate the OB trauma numbers. While it is recognized that the Asian population has a higher incidence for these complications, we continue to explore interventions that may serve as countermeasures.	
8. PROGRESS ON QUALITY AND SAFETY PLAN	Dr. Adams reported on the Quality and Safety Plan progress. He stated that this report is an update noting that the outcomes are what ultimately matter and not just the process. The goal is to get high quality and safety outcomes. Some insights of the work the hospital is doing to get those outcomes include instituting "iCough" that is designed to reduce the incidence of hospital	

	acquired pneumonia, better use of the Sepsis Bundle designed to reduce Sepsis Mortality and introduction of the ERAS program that is designed to get surgical site infections reduced. Dr. Adams stated that the ERAS program is a bigger program with more moving parts and is designed to get the hospital's surgical site infection rates reduced. In response to committee members' questions, Dr. Adams stated that the hospital did a pilot study with the GYN/oncologists a year ago. The success that was seen in that pilot program had been brought throughout the whole organization. He stated that in the next quarter management should have some data.	
9. SYSTEMATIC APPROACH TO TRIGGERS FOR ADDING BACK IN METRICS FOR REVIEW	Dr. Adams reported on the Systematic Approach to Triggers for Adding Back in Metrics for Review. Dr. Adams stated there were questions about circling back around the enterprise quality dashboard and also about putting an area back on the dashboard. Dr. Adams stated that in general, the dashboards do not change during the year since it takes some time to track the data over the year. He stated that if there is something that is getting out of control, he would bring that to the Quality Committee's attention. In response to a committee member's question, Dr. Adams stated transparency is important and would bring back any measurements that are getting out of control. He stated that it would not be put on the dashboard par say, but he would most definitely bring that to the committee's attention. Dr. Po suggested to have a criteria of if a number reaches a certain level, then it should be brought to the committee and not just by best judgement. Chair Kliger suggested to bring this back in February to provide the clear line of when the data should come forward.	
10. PUBLIC COMMUNICATION	There was no public communication.	
11. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 6:44pm. **Movant:** Kan **Second:** Burn **Ayes:** Burn, Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Adjourned to closed session at 6:44pm***
12. AGENDA ITEM 17: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:33pm. Agenda items 12-16 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (11/02/2020), Quality Council Minutes, and Medical Staff Credentialing and Privileges Report.	
13. AGENDA ITEM 18: CLOSING WRAP UP	There were no closing comments.	
14. AGENDA ITEM 19: ADJOURNMENT	**Motion:** To adjourn at 7:34pm. **Movant:** Kan **Second:** Simon **Ayes:** Burn, Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None	***Meeting adjourned at 7:34pm***

	Absent: None **Recused:** None	

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

_____
Julie Kliger, MPA, BSN
Chair, Quality Committee

Prepared by: Yurike Arifin

El Camino Health

FY21 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

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

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

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

GOALS	TIMELINE	METRICS
1. Review the Hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality	- FY20 Achievement and Metrics for FY21 (Q1 FY21) - FY22 Goals (Q3 – Q4)	Review management proposals; provide feedback and make recommendations to the Board
2. Alternatively (every other year) review peer review process and medical staff credentialing process; monitor and follow through on the recommendations	Q2	- Receive update on implementation of peer review process changes (FY22) - Review Medical Staff credentialing process (FY21)
3. Review Quality, Patient Care and Patient Experience reports and dashboards	- FY21 Quality Dashboard (Q1-Q2 proposal; monthly for review and discussion, if needed) - CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS), ED Patient Satisfaction (x2 per year) - Leapfrog survey results and VBP calculation reports (annually)	Review reports per Pacing Plan timeline –
4. Review Effectiveness of Board Dashboard using STEEEP Methodology and propose changes if appropriate	Semi – Annually Q2 and Q4	Review Dashboard and Recommend Changes
5. All committee members regularly attend and are engaged in committee meeting preparation and discussions	Using closing wrap up time, review quarterly at the end of the meeting	Attend 2/3 of all meetings in person Actively participate in discussions at each meeting

SUBMITTED BY: **Chair**: Julie Kliger, MPA, BSN
Executive Sponsor: Mark Adams, MD, CMO

Approved by the El Camino Hospital Board of Directors 6/10/2020

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: January 25, 2021
Subject: FY21 Enterprise Quality, Safety, and Experience Dashboard

Summary:

1. Situation: The 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 are selected based on a careful 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.

- **A.** Provide the Committee with a snapshot of the FY 2020 metrics monthly with trends over time and compared to the actual results from FY2019 and the FY 2020 goals.
- **B.** Annotation is provided to explain

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

3. Background: At the beginning of each fiscal year, an assessment is completed to identify specific areas for quality/performance improvement. A subset of these areas are then prioritized and designated as leading indicators to be tracked universally throughout the organization so that all clinicians—physicians included—and support staff are aligned in the improvement activities. Measures that demonstrate sustained improvement are removed (but still tracked) and others added. These twelve (12) metrics were selected for monthly review by this Committee as they reflect the Hospital's FY 2021 Quality, Efficiency and Service Goals.

4. Assessment:

- **A.** Readmission Index remains under target since April 2020
- **B.** SSEs are at 4 for October 2020, each SSI is an SSE
- **C.** Mortality Index increased to 0.81 above target with 48 deaths in December
- **D.** HCAHPS Likelihood to Reccommend below target for hospital with impact of COVID surge and limitation on visitors. ED LTR has improved and above target for ECHMN
- **E.** 2 C.Diff HAIs for the December in severely ill patients
- **F.** Sepsis mortality Index up slightly in December with 58% of December deaths due to Sepsis.
- **G.** PC-01 increased above target, cases are individually reviewed
- **H.** PC-02, Cesarean Birth rising slightly from August, change in volume in LG due to new OB/GYNs
- **I.** Patient Throughput up with COVID surge

See additional detailed comments in the annotation of the report

5. Other Reviews: None

6. Outcomes: N/A

Suggested Committee Discussion Questions: None

List of Attachments: FYTD 2021 Enterprise Quality, Safety, and Experience Dashboard, December data unless otherwise specified - final results

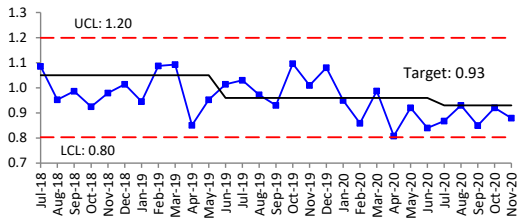
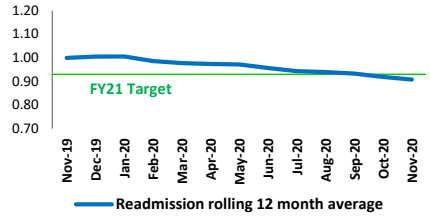
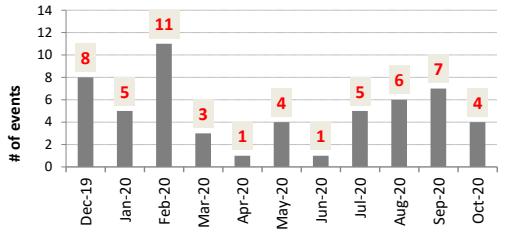
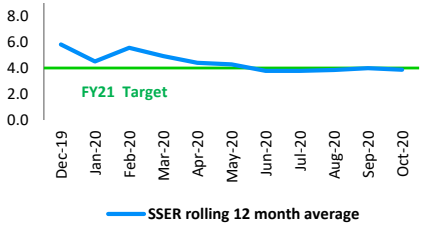
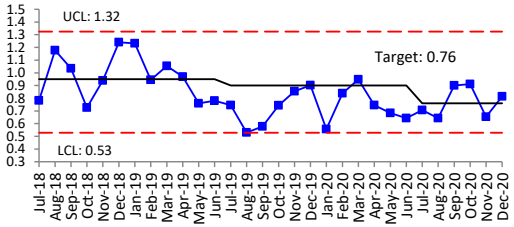
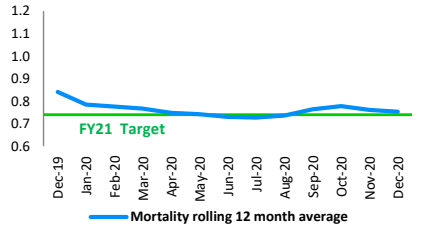
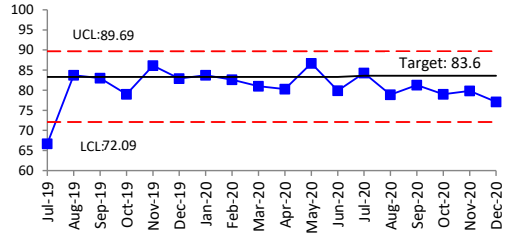
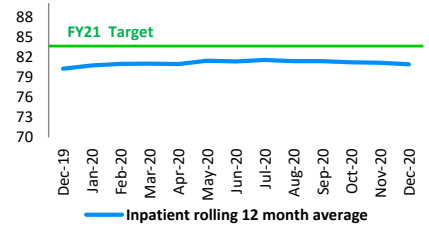
El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

December 2020 (unless otherwise specified)

Month to Board Quality Committee:

February, 2021

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** ***Latest data month: November 2020*	0.88 (7.03%/8.00%)	0.89 (7.28%/8.18%)	0.96	0.93		
2	*Organizational Goal **Serious Safety Event Rate (SSER)** # of events/ (FYTD Rate) ****Latest data month: October 2020*	4	3.87 (55/142274)	4.28	4.0		
3	* Strategic Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: December 2020*	0.81 (2.96%/3.64%)	0.77 (1.69%/2.20%)	0.74	0.76		
4	*Organizational Goal **IP Enterprise - HCAHPS Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: December 2020*	77.1	79.5	83.1	83.6		

Definitions and Additional Information

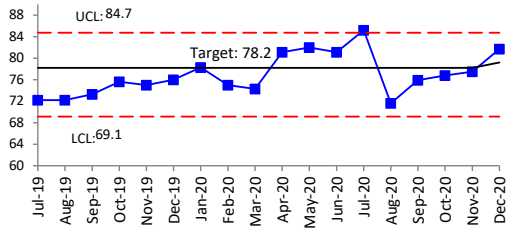
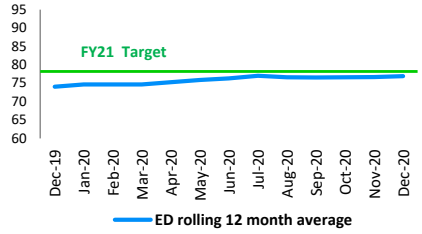
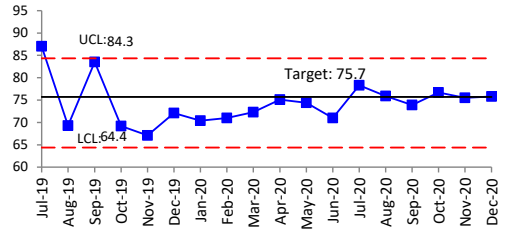
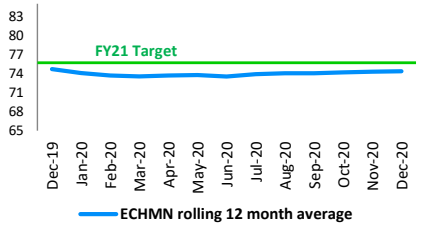
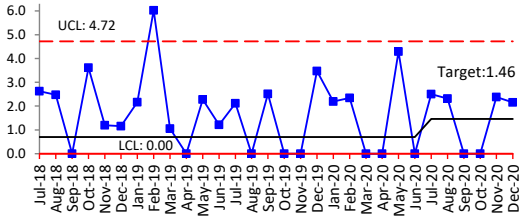
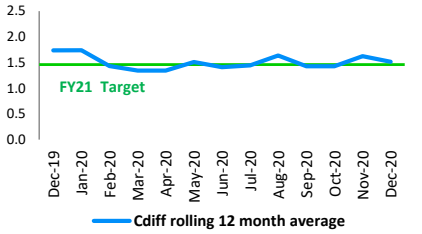
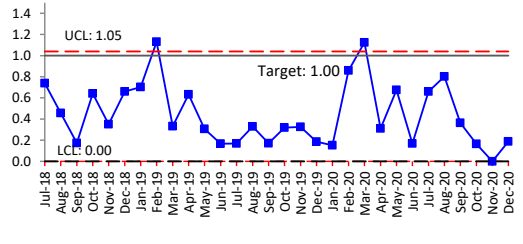
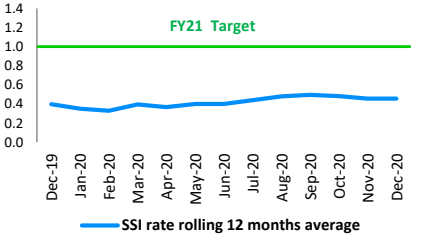
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
1. Readmission Index - All Patient All Cause Readmit (Observed/Expected)	Readmission Index continues to stay below target. 7 teams meet at least monthly to address issues that affect readmissions. Some of the improvements being implemented include discharge phone calls, Using EPIC tool for post discharge care plans and follow up, including service line leaders in readmission case review, implementing proactive treatments to prevent chemo/radiation complications, and work across the Enterprise to improve ambulation of patients so they are ready to go home and do not get readmited for weakness. 86 Readmissions in November, 108 in October.	Catherine Carson	Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted). Includes Inpatient and Psych patients. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
2. Serious Safety Event Rate (SSER)	4 SSE's in October: - 1 SSI, 2 HAPI, 1 retained surgical specimen requiring readmit/return to OR	Sheetal Shah	Definition of serious safety event is an event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. Inclusion is events determined to be serious safety events per Safety Event Classification team *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**HPI**
3. Mortality Index (Observed/Expected)	48 deans in November with good documentation of severity and co-morbidities with an expected value of 2.2%. All mortalities screened by peer review staff with review of each patient's risk of mortality and severity of illness.	Catherine Carson	Updated 7/1/19 (JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
4. Inpatient - HCAHPS Likelihood to Recommend Top Box Rating of 'Always' % , Unadjusted	As are most hospitals around the country, LTR is not at target due to the pandemic. However, ECH Inpatient remains above the California and the National average. The nursing leadership team has a committed focus to nurse leader rounding and a detailed plan has been put in place to improve our scores.	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

December 2020 (unless otherwise specified)

Month to Board Quality Committee:
February, 2021

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Month Average
		Latest month	FYTD				
5	* Organizational Goal **ED Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: December 2020*	81.7	76.5	75.7	78.2		
6	* Organizational Goal **ECHMN** (El Camino Health Medical Network)**: Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: December 2020*	75.8	76.1	73.2	75.7		
7	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Latest data month: December 2020*	2.15 (2/9296)	1.52 (8/52653)	1.46	<= 1.46 (MV: 10/ LG: 3)		
8	Organizational Goal **Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Latest data month: December 2020*	0.19 (1/531)	0.37 (13/3509)	0.36	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

Definitions and Additional Information

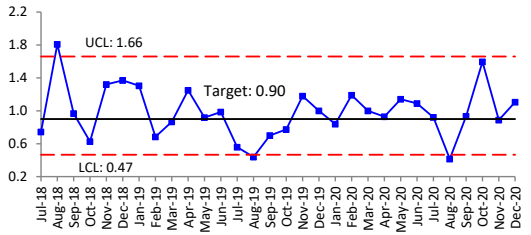
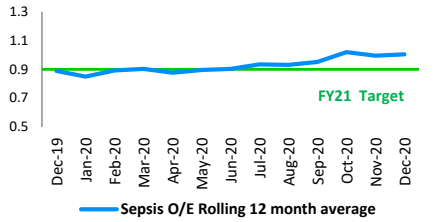
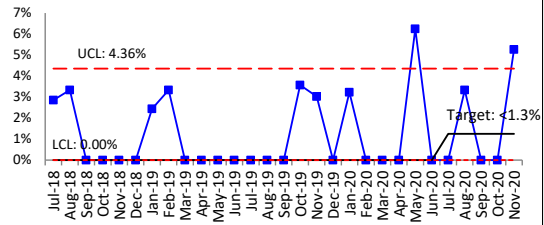
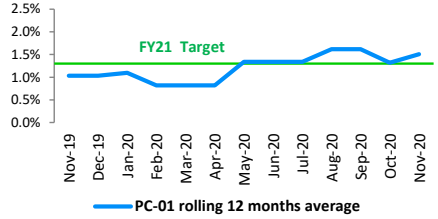
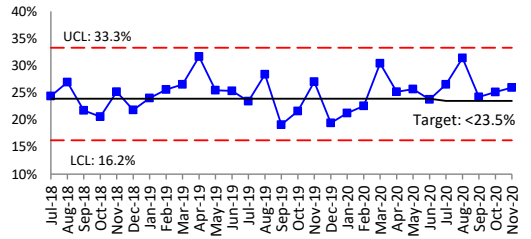
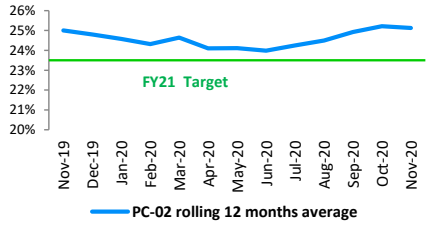
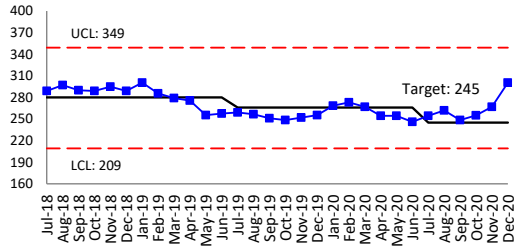
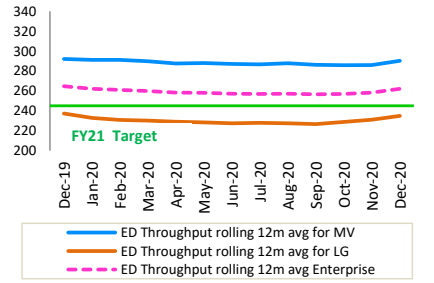
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
5. ED - Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted	The ED is continuing to focus on processes and communications to ensure our patients and families feel safe. Continued rounding, WeCare training and 'buttons' with staff photos are in process.	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**
6. ECHMN (El Camino Health Medical Network) - Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted	Our outpatient sites continue to be at target in spite of the pandemic. The recent WeCare 'words that work' are being incorporated into our new vaccine clinic.	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**
7. Hospital Acquired Infection- C. Diff (Clostridium Difficile Infection)	2 cases of Hospital-acquired C. Diff in December. 1-54 y/o pt. admitted for lymphoma, had received antibiotics on previous admission, 2- 87 y/o admitted with chronic osteomyelitis, and continued antibiotics.	Catherine Carson/Catherine Nalesnik	Infection Rate is predicted infections to meet Target/Goal: NHSN SIR. Inclusion criteria: in-patients only, based on NHSN definition Exclusion: ED and OP FY21 Target/ Goal received from Catherine N.'s email of 9/1/20. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**CDC NHSN database - Inf. Control** **Patient Days from EPIC**
8. Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100	1 SSI in December: Ovarian cystectomy with readmission for pelvic abscess. Pt had no Preop antibiotics, and concern with hair clipping in the OR. OR and Procedural staff given the BD Surgical Prep Observation report in January. BD, OR and Materials Management developing a standardized list of Surgical Preps. Education of OR and procedural staff in proper surgical preps began in January with return demonstrations.	Catherine Carson/Catherine Nalesnik	**Inclusion:** 1) Based on NHSN defined criteria 2) All surgical cases that are categorized as "clean wound class" and "clean-contaminated wound class" are considered for investigation 3) SSIs that are classified: "deep –incisional" and "organ-space" are reportable **Exclusion:** 1) All surgical cases that have a wound class of "contaminated" and "dirty" are excluded. 2) All surgical case that are considered an infection PATOS (present at time of surgery). 3) All "superficial" SSIs are not reportable FY21 Target/ Goal received from Catherine N.'s email of 9/1/20. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average .Lower Control Limit is not visible if it is less than or equal to zero .*	**CDC NHSN database - Inf. Control**

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

December 2020 (unless otherwise specified)

Month to Board Quality Committee:
February, 2021

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Month Average
		Latest month	FYTD				
9	**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)* *Latest data month: December 2020*	1.11 (17.58%/15.88%)	0.98 (12.01%/12.20%)	0.98	0.90		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) **Latest data month: November 2020*	MV: 6.25% (1/16) LG: 0.0% (0/3) **ENT: 5.26%** (1/19)	MV: 1.08% (1/93) LG: 3.23% (1/31) **ENT: 1.61%** (2/124)	MV: 1.47% (5/341) LG: 0.00% (0/48) **ENT: 1.29%** (5/389)	1.3%		
11	**PC-02: Cesarean Birth** (lower is better) **Latest data month: November 2020*	MV: 25.2% (33/131) LG: 29.6% (8/27) **ENT: 25.9%** (41/158)	MV: 27.8% (194/697) LG: 22.0% (33/150) **ENT: 26.8%** (222/847)	MV: 24.7% (412/1665) LG: 18.9% (48/253) **ENT: 23.9%** (460/1918)	23.5%		
12	***Strategic Goal** **Patient Throughput- Median Time from Arrival to ED Departure** *(excludes psychiatric patients, patients expired in the ED and Newborns)* *Latest data month: December 2020*	MV: 330 min LG: 271 min **Ent: 301 min**	MV: 285 min LG: 245 min **Ent: 265 min**	MV: 304 min LG: 263 min **Ent: 284 min**	MV: 263 min LG: 227 min **Ent: 245 min**		

** PC-01 and PC-02 data available up to November. 2020

*** SSER data available up to October, FYTD data displayed in rate per 10000 Acute Adjusted Patient Days for the reporting period December 2019 to October 2020

Report updated: 1/19/20

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
9. Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	28 of the 48 deaths in December had a Sepsis diagnosis - 58%. All cases are reviewed for documentation and adherence to the Sepsis bundle. Issues continue with shock progression, prolonged hypotension and inadequate fluid bolus.	Jessica Harkey, Catherine Carson	Effective 01/24/20: The original definition for Sepsis (used in this dashboard) 1) evaluated only the Principal diagnosis, & 2) excluded cases assigned the patient type of Rehabilitation or Other (Hospice). The definition has now been aligned with CMS' to 1) evaluate both principal AND secondary diagnoses, & 2) excludes: patients < 18 years, LOS => 120 days, or Transfers from Another Acute Hospital, as well as the Patient Type of Rehabilitation or Other (Hospice). This was reviewed with & approved by Jessica Harkey, Sepsis Manager and Catherine Carson Sr. Director Quality. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
10. PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed	2 cases overall: 1 provider scheduled < 39wks and states scheduling error, no medical indication. One patient needed to be delivered for medical indication, but still counts against EED. Our system is a prospective review of EED cases and reaching out to contact providers if patients appear to be inappropriately scheduled. This usually happens when a patient requests a certain date and is able to push the MA and registration to schedule. We do not yet have a hard stop for patients if they arrive < 39wks without an indication. This would be very hard for patients and providers and we have tried to do our best to not need to enact this more aggressive tactic. Providers with EED are trended and reaching out to them individually if there was not a medical indication to let them know of our approach and need to eliminate these cases.	TJC	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
11. PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	Enterprise wide, there is an increase in MD volume deliveries at LG and this has increased the NTSV rate over midwife deliveries. From a system standpoint we are working at addressing the procedures we have in place for managing the labor process from beginning with early labor/induction of labor through delivery to minimize NTSV at a level that is safe. Initial focus in on our induction processes to help target this. Separately, we are also meeting with individual physicians who are outliers in the NTSV category to educate and explore ways that they may need support to achieve a reduced NTSV rate. We are at the stage of education and monitoring for these individuals.	TJC	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
12. Patient Throughput- Median Time from Arrival to ED Departure (excludes psychiatric patients, patients expired in the ED and Newborns	The Patient Throughput Value Stream continues to work on stabilizing the electronic SBAR handoff, Capacity Management Center (CMC), and nurse staffing. A full-time PFC (Patient Flow Coordinator) has been hired and will take over management of the patient flow process. Throughput times continue to be high and are correlated with the high volume of admitted COVID patients. The testing process, along with the need for increased staff to care for them, is contributing to throughput delays. As the volume of COVID patients decreases in the coming months, we expect throughput numbers to recover. The project is moving into the next phase of working on centralized staffing and bed planning, with the goal of reducing any delays in patient throughput related to staffing. We are leveraging the capabilities in EPIC to give more visibility to daily nursing assignments and advanced scheduling.	Cheryl Reinking, Melinda Hrynewycz	This measure definition is changed in Feb. 2020 regarding the end point. New definition is "Arrival to ED Departure", and is the same as CMS ED Measure (ED 1b) ED Arrival to ED Departure for Admitted pts. Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, and newborns. Arrival: Patient Arrived in ED Head in Bed: Patient admitted in unit *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**iCare Report: ED Admit Measurement Summary**

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: February 1, 2021
Subject: Report on Board Actions

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

Summary:

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

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

3. Background: Since the last time we provided this report to the Quality, Patient Care and Patient Experience Committee, the Hospital Board has met once and the District Board has met twice. In addition, since the Board has delegated certain authority to the Executive Compensation Committee, the Compliance and Audit Committee and the Finance Committee, those approvals are also noted in this report.

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	December 9, 2020	- FY21 Period 3 and 4 Financials - FY20 CEO Incentive Compensation Payment - Quality Committee Report Including Credentials and Privileges Report
ECHD Board	December 4, 2020	- Accepted the November 3, 2020 Election Results (John Zoglin, Julia E. Miller and Carol A. Somersille, MD elected) - Elected Carol A. Somersille, MD to the El Camino Hospital Board of Directors - Appointed Julia E. Miller as Vice Chair of the ECHD Board
	December 29, 2020	- Endorsed John Zoglin as Candidate for Alternate Independent Special District Member of Santa Clara County LAFCo - Approved $100,000 in funding for Community COVID-19 Vaccination Program
Executive Compensation Committee	N/A	
Compliance and Audit Committee	N/A	

Report on Board Actions
February 1, 2021

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
Finance Committee	N/A	

List of Attachments: None.

Suggested Committee Discussion Questions: None.

Quality Committee Follow up Item Tracking Sheet (07/23/2020)

#	Follow Up Item	Date Identified	Owner(s)	Status	Date Complete
1	Bring "negative" (not only positive) patient stories for discussion	11/4/2019	CR	Noted in Pacing Plan 12/2/19 going forward	Ongoing
2	Add control limits to Annual PI Reports	11/4/2019	CC/MA	Will be added to future reports	Ongoing
3	Look deeper into the the sytem for non-nursing related issues for the patient stories	12/2/2019	CR	Open	Ongoing
4	Cover Memos - Make sure to state what the staff wants from the committee/how the committee can be helpful and provide discussion questions	12/2/2019	Executive Team	Open	Ongoing
5	Provide more trending information on readmissions data	12/2/2019	CC/MA	Open	Ongoing
6	Make the charts and graphs easier to read	12/2/2019	CC/MA	Open	Ongoing
7	Add Review of Lean Projects to Pacing Plan for FY21	3/2/2020	JG	Added to March 2021 Meeting	

The New York Times
The Morning

January 18, 2021

‘We’re underselling the vaccine’

Early in the pandemic, many health experts — in the U.S. and around the world — decided that the public could not be trusted to hear the truth about masks. Instead, the experts spread a misleading message, discouraging the use of masks.

Their motivation was mostly good. It sprung from a concern that people would rush to buy high-grade medical masks, leaving too few for doctors and nurses. The experts were also unsure how much ordinary masks would help.

But the message was still a mistake.

It confused people. (If masks weren’t effective, why did doctors and nurses need them?) It delayed the widespread use of masks (even though there was good reason to believe they could help). And it damaged the credibility of public health experts.

“When people feel as though they may not be getting the full truth from the authorities, snake-oil sellers and price gougers have an easier time,” the sociologist Zeynep Tufekci wrote early last year.

Now a version of the mask story is repeating itself — this time involving the vaccines. **Once again, the experts don’t seem to trust the public to hear the full truth.**

This issue is important and complex enough that I’m going to make today’s newsletter a bit longer than usual. If you still have questions, don’t hesitate to email me at themorning@nytimes.com.

‘Ridiculously encouraging’

Right now, public discussion of the vaccines is full of warnings about their limitations: *They’re not 100 percent effective. Even vaccinated people may be able to spread the virus. And people shouldn’t change their behavior once they get their shots.*

These warnings have a basis in truth, just as it’s true that masks are imperfect. But the sum total of the warnings is misleading, as I heard from multiple doctors and epidemiologists last week.

“It’s driving me a little bit crazy,” Dr. Ashish Jha, dean of the Brown School of Public Health, told me.

“We’re underselling the vaccine,” Dr. Aaron Richterman, an infectious-disease specialist at the University of Pennsylvania, said.

“It’s going to save your life — that’s where the emphasis has to be right now,” Dr. Peter Hotez of the Baylor College of Medicine said.

The Moderna and Pfizer vaccines are “essentially 100 percent effective against serious disease,” Dr. Paul Offit, the director of the Vaccine Education Center at Children’s Hospital of Philadelphia, said. “It’s ridiculously encouraging.”

The details

Here's my best attempt at summarizing what we know:

- The Moderna and Pfizer vaccines — the only two approved in the U.S. — are among the best vaccines ever created, with effectiveness rates of about 95 percent after two doses. That's on par with the vaccines for chickenpox and measles. And a vaccine doesn't even need to be so effective to reduce cases sharply and crush a pandemic.
- If anything, the 95 percent number understates the effectiveness, because it counts anyone who came down with a mild case of Covid-19 as a failure. But turning Covid into a typical flu — as the vaccines evidently did for most of the remaining 5 percent — is actually a success. Of the 32,000 people who received the Moderna or Pfizer vaccine in a research trial, do you want to guess how many contracted a severe Covid case? One.
- Although no rigorous study has yet analyzed whether vaccinated people can spread the virus, it would be surprising if they did. "If there is an example of a vaccine in widespread clinical use that has this selective effect — prevents disease but not infection — I can't think of one!" Dr. Paul Sax of Harvard has written in The New England Journal of Medicine. (And, no, exclamation points are not common in medical journals.) On Twitter, Dr. Monica Gandhi of the University of California, San Francisco, argued: "Please be assured that YOU ARE SAFE after vaccine from what matters — disease and spreading."
- The risks for vaccinated people are still not zero, because almost nothing in the real world is zero risk. A tiny percentage of people may have allergic reactions. And I'll be eager to see what the studies on post-vaccination spread eventually show. But the evidence so far suggests that the vaccines are akin to a cure.

Offit told me we should be greeting them with the same enthusiasm that greeted the polio vaccine: "It should be this rallying cry."

The costs of negativity

Why are many experts conveying a more negative message?

Again, their motivations are mostly good. As academic researchers, they are instinctively cautious, prone to emphasizing any uncertainty. Many may also be nervous that vaccinated people will stop wearing masks and social distancing, which in turn could cause unvaccinated people to stop as well. If that happens, deaths would soar even higher.

But the best way to persuade people to behave safely usually involves telling them the truth. "Not being completely open because you want to achieve some sort of behavioral public health goal — people will see through that eventually," Richterman said. The current approach also feeds anti-vaccine skepticism and conspiracy theories.

After asking Richterman and others what a better public message might sound like, I was left thinking about something like this:

We should immediately be more aggressive about mask-wearing and social distancing because of the new virus variants. We should vaccinate people as rapidly as possible — which will require approving other Covid vaccines when the data justifies it.

People who have received both of their vaccine shots, and have waited until they take effect, will be able to do things that unvaccinated people cannot — like having meals together and hugging their grandchildren. But until the pandemic is defeated, all Americans should wear masks in public, help unvaccinated people stay safe and contribute to a shared national project of saving every possible life.

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
Date: February 1, 2021
Subject: Patient Story

Purpose: To provide the Committee with patient feedback that is received by the organization and actions taken, if necessary, to improve the patient experience

Summary:

Situation: This letter was received by the Patient Experience Department and shared with the Maternal Child Health leaders and staff. The patient feedback is related to his/her care by the MCH area including Labor and Delivery, Mother Baby Unit (MBU), and Lactation Consulting (LC). While the care and experience was noted as "terrific" in Labor and Delivery department, the MBU and Lactation were noted as poor and needing improvement from this patient's perception.

Authority: To view patient feedback.

Background:

- This letter was provided by a patient receiving care in MCH. The patient provides a general overview of her care and is complimentary of her experience in labor and delivery. However, she indicates concerns with the lactation consultant's attitude and knowledge.
-
- 2. Assessment: The new mother made very important points that has allowed us to assess our lactation consultant's knowledge and attitudes as well as to review the educational support we provide our new mothers regarding lactation.

Other Reviews: MCH leaders and Staff have reviewed and made changes based on the feedback.

Outcomes: First, the manager of the lactation consultants performed service recovery. The manager called the patient to apologize for her experience. The Team has made changes as a result in the letter that includes reviewing the educational modules for our patients for appropriateness. In addition, the lactation consultants have changed their schedules. A first visit will occur on the day of delivery (or morning after) to start the lactation support/education. Early intervention will allow for mothers to have an assessment early to review the breast feeding challenges with our new mothers. Follow-up visits can occur during the hospital stay if the initial visit is early to evaluate the effectiveness of the interventions. Finally, OP LC appointments can also be scheduled for further follow up if the new mother is still having difficulty before leaving the hospital. New mothers need to know they have support available as feeling overwhelmed happens with any new mom, ECH needs to support these families proactively. In addition, education on this patient's condition "prolactoma" was communicated to the LC's for their own education. Finally, feedback was given to the staff regarding WeCare behaviors we expect as caregivers for our new families.

List of Attachments: Patient Letter

Suggested Committee Discussion Questions:

1. How was the service recovery perceived by the patient?
2. Are there more actions to come as a result of the feedback?

Hello,

My mom is an employee at El Camino Hospital, and after she spoke with a colleague about my experience delivering at ECH, her colleague suggested I send an email.

I'd summarize my experience as:

- Terrific experience with Labor & Delivery
- Extremely poor experience with Mother & Baby, Lactation Consultant

Labor & Delivery

- When I arrived early Monday morning, the nurses and doctors saw how much pain I was in. I felt they were doing everything in their power to give me some relief. Dr. White made me feel really relaxed despite the intense pain I was in. She cracked jokes to lighten the mood, and I was so appreciative.
- The anesthesiologist administered the catheter and medicine with little discomfort, and I was able to sleep the entire day as I continued my labor. The nurse who helped hold me really made me feel relaxed during a very nervous process for me. After the epidural, it was the easiest delivery that I could've imagined!
- Dr. Wong, my OB, worked so deftly as she caught my son, and then went to work with the delivery of the placenta and stitching me up.
- Every nurse and doctor who came into my room that day checked in to make sure my husband and I were ok. And after my son was born, so many nurses came in to congratulate us and marvel at his massive head of hair. :)
- El Camino's L&D department is so wonderful, and I am very grateful for that experience.

Mother & Baby Unit & Lactation Consultant

- It took a while for the call button to be answered on more than one occasion. It was challenging when I couldn't get my son to latch. The nursing staff did not listen when I expressed concerns that I was producing nothing. I was told it was normal for the milk to take a few days to come in.
- The lactation consultant was rushed, condescending, and made me feel like a failure.
- She was obviously very busy and made us feel like we were inconveniencing her. She told us to watch a video and then if we had any questions to call her.
- The video: The video was not helpful and actually made me feel more discouraged since the babies were obviously not newborns and the mothers had a good supply of milk that I doubt most new mothers have right away.
- We reached out to the nurse and confirmed that the lactation consultant was aware we were waiting for her. She finally returned at 11:45 am (our discharge was supposed to be at 11.) She told me that she had worked with other mothers who had "misshapen breasts," and they were

all still able to produce. It felt almost like she was implying there was something wrong with me. I told her I could not manually express any colostrum, and she tried to help explain how to do it. However, once she was unable to get anything either, she said that everyone has a different "sweet spot," and I would just have to keep trying. It felt dismissive. I was a first-time mom stressed about feeding my newborn, and she made me feel defeated.

- My husband had mentioned to her that I had a history of a prolactinoma removed through surgery in December 2019. He asked her if that might be the cause of the lack of production. She said it wouldn't be an issue because I was clearly able to produce something before since the prolactinoma caused my prolactin levels to be so high last year. When the consultation was over (without her observing me even trying to breastfeed my son), I felt completely overwhelmed with emotion and guilt about my inability to feed my child. Thankfully, the nurse on duty suggested I take some formula home to supplement the breastmilk "just in case."

- After pumping for 2 weeks as the LC suggested, I ended up getting bloodwork done through my doctor, who confirmed I was, in fact, unable to produce milk because of that surgery. This is something I feel a Lactation Consultant should be familiar with.

- Despite this terrible experience, there was one nurse who was patient with me and taught us how to swaddle. She spent some time talking with us and reassuring us that we would figure it out despite how overwhelmed we were feeling. I can't remember her name, but I was very appreciative of her help. She had a nursing student observing her, and he was also really sweet and chatted with us for a bit too.

I hope this feedback is helpful. I would hate for another new mom to leave feeling as overwhelmed as I did.

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: February 1, 2021
Subject: SVMD Quarterly Quality Report

Purpose: Provide the Board Quality Committee with a quarterly update on the status of SVMD 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 SVMD. It was agreed that the Board Quality Committee would review the status of quality and service performance within SVMD 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: SVMD 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 SVMD with respect to quality and service:

A. HEDIS (Healthcare Effectiveness Data and Information set)
B. MIPS (Medicare Incentive Payment System)
C. NPS (net promoter score)

ECHMN has established true north pillars, one of which is quality and service. For quality, the goals are: achieve top decile HEDIS composite score by 2023 and achieve MIPS composite exceptional rating annually. While there are many more HEDIS measures, 8 key metrics have been selected based on importance to patient care, impact on financial reimbursement, and concordance with MIPS measures. The latest quarter results show improvements in all 8 categories of HEDIS measures with composite score improvement to 3.375.

Work has continued on improving the CMS Merit-based Incentive Payment System (MIPS) score. The latest results show SVMD scoring 86% which qualifies SVMD for the exceptional bonus level. This is not only excellent achievement in quality but will result in a financial benefit in the form of a CMS bonus. (to be determined in August of this year)

Finally, the NPS score for ECHMN is included which has shown a steady improvement. Net Promoter Score is calculated by asking patients to rate on a 1 to 10 scale their likelihood to recommend. The percent of 9's and 10's is reduced by the number of 1's through 5's. (6, 7, and 8's do not count). The FYQ2 NPS score for SVMD is 75.7 compared to 76.2 for FYQ1. Baseline FY20 was 72.3.

5. Outcomes: SVMD quality performance improvement is showing positive signs of increased results based on this latest data. Processes are now in place to make further improvements.

List of Attachments:

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

Suggested Committee Discussion Questions:

What areas should SVMD be focusing on to improve service?
How do committee members assess the quality of care they are receiving from their physician?
What additional information would be helpful for the committee to have to satisfy any concerns about quality and service in SVMD?

El Camino Health

SVMD Quarterly Quality Report

Mark Adams, MD
Chief Medical Officer
February 01, 2021

2020/21 Quality Metrics

- SVMD selected 8 Quality Outcome Metrics to monitor, measure and improve.
- The selected metrics are representative indicators of how well SVMD performs as a system in preventative care, curative care and chronic disease management.
- *Epic* and MIPS scoring data and ranking system were used as the benchmark for provider and system level reporting.
- For strategic and high level target setting purposes, a "**1-5 Composite Scoring system**" was developed utilizing EPIC and MIPS deciles.
    - Quality Measure were given a 1-5 score range reflecting the corresponding range in their respective MIPS ranges.
    - A "**1**" signifying the lowest decile range and "5" being in the highest decile range.
    - The composite score is the total points for the 8 measures divided by 8

Quality Metrics

Measure ID	Points 1	Points 2	Points 3	Ponits 4	Points 5	Epic/ MIPS Perfor-mance Score	Compo-site Measure Score	Target	Target Point Score
Documentation of Current Medications in the Medical Record	0-6.45	6.46-88.81	88.82-99.68	99.69-100	100	89	3	89	3
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	0-0.41	0.42-23.88	23.89-73.96	73.97-98.35	98.36-100	53	3	47	3
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) **	>99.46	99.45-92.62	92.61-59.09	59.08-37.89	37.88-31.41	29	5	45	4
Breast Cancer Screening	0-0.27	0.28-27.28	27.29-69.35	69.36-88.26	88.27-100	54	3	48	3
Colorectal Cancer Screening	0-0.12	0.13-19.33	19.34-70	70.01-90.81	90.82-100	45	3	45	3
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0-0.92	0.93-24.15	24.16-90.28	90.29-99.99	100	94	4	90	4
Falls: Screening for Future Fall Risk	0-0.03	0.04-21.67	21.68-90.35	90.36-99.5	99.6-100	83	3	56	3
Controlling High Blood Pressure	0-19	20-39.99	40-59.99	60-79.99	80-100	56	3	63	4
Total							**3.375**		**3.375**

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SVMD Leading HealthCare Metrics
Target Versus Actual as of September 2020

Metric	Target	July-Sept 20 Performance	Trend vs Prior Quarter
COMPOSITE SCORE	3.0	3.25	↑
Documentation of Current Meds	89%	83%	↑
BMI Screening and Intervention	47%	45%	↓
Hemoglobin A1C	less than 45%	31%	↓
Breast Cancer Screening	48%	42%	↓
Colorectal Cancer Screening	45%	31%	↑
Tobacco Screening and Intervention	90%	92%	↑
Fall Screening	56%	46%	↑
Controlling Blood Pressure	63%	59%	↑

El Camino Health

SVMD Leading HealthCare Metrics Targets v. Actuals as of January 7, 2021

Metric	Target	4th Qtr YTD	Trend vs Prior Quarter
COMPOSITE SCORE	3	3.3	↑
Documentation of Current Meds	89%	90%	↑
BMI Screening and Intervention	47%	53%	↑
Hemoglobin A1C	less than 45%	29%	↓
Breast Cancer Screening	48%	54%	↑
Colorectal Cancer Screening	45%	43%	↑
Tobacco Screening and Intervention	90%	94%	↑
Fall Screening	56%	83%	↑
Controlling Blood Pressure	63%	56%	↑

- Year-to-date composite score is 3.375. This exceeds the target of 3.0.
- 6/8 measures are above target.
- 2/8 measures are below target but are demonstrating improvement.

El Camino Health

2020 MIPS as of January 7, 2021

- MIPS Calculation will be finalized in August
- The 2020 data will be submitted to CMS in February
- When we last reported to the Board, our MIPS overall performance was 82% and we were focusing efforts to improve our score to at least 85%
- The current data shows SVMD TIN achieved a score of 86%, which puts SVMD at the exceptional bonus level
- Our Care Gap closure has improved in both the quality and Performance Improvement components of the score
- 60 Individual Physicians achieved over 85% (which allows us to file their individual performance in addition to the group performance)
- Final calculation will be made by CMS and we should find out our final score sometime in August

January Quality Committee Decisions

- Approved the committee structure and membership proposal

- Approved selection criteria for new providers
  - Provider must be board certified or board eligible
  - If foreign medical graduate, need to complete US ACGME approved residency program
  - Must have a current DEA License
  - Not on the OIG Medicare/Medical Exclusion list
  - Strong references
  - Pro-active reference checking

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: February 1, 2021
Subject: Board Quality and Safety Dashboard

Purpose: To review the Q2 Board Quality and Safety Dashboard.

Summary:

1. Situation: The Quality Committee reviews the quarterly Board Quality and Safety Dashboard preceding submission to the Board.

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

3. Background: This dashboard is designed to provide the Board with a standardized high level snapshot of overall quality and safety. It is provided on a quarterly basis. Each quarter is scored separately with a FYTD21 total presented in the last column. This dashboard is based on the STEEEP definition of quality and safety that is a national standard adopted by the IHI (Institute for Healthcare Improvement).

4. Assessment: The Board's Quality Committee will continue to review the more sophisticated control charts and more detailed analysis of topics requiring attention but the Board will rely on this dashboard as included in the Quality Committee report. The intent is to review those areas of potential concern (in red) and are noted below according to the Quality Domain:

A. Safe Care:
- i. SSER is slightly below target accompanied by some good news that Surgical Site Infections are down significantly
- ii. CAUTI: 4 total; 1 COVID patient requiring prolonged ICU care; 3 secondary to prolonged catheterization following urinary retention
- iii. C.Diff: 4 cases total; one failed screening
- iv. CLABSI: 4 total; 1 secondary to urinary infection source; 1 secondary to a longstanding chemotherapy port; 1 related to improper culture from the line

B. Timely:
- i. All three ED measures showed increases related to increasing COVID census; combination of waiting for test results and delays because of bed availability

C. Effective Care:
- i. CMS SEP-1 Compliance rate: increased in Q2 to 81.8% but still below internal goal; CMS median rate is 60% across all hospitals.
- ii. PC-01: 1 case as in Q1 but lower denominator resulted in higher rate: 1.89%
- iii. PC-02 C/S rate: decreased but still above target of 23.5% focused interventions on several outliers underway (one practitioner has a rate of 45% for example)

D. Efficient Care:
- i. ALOS/Expected LOS: Long term patients difficult to discharge and place including COVID-19 pts. impact this metric.

E. Equitable Care: no issues

F. Patient-Centered Care:

i. IP enterprise slightly decreased. ED improved, MCH decreased, outpatient surgery improved. The lack of patient visitation due to COVID pandemic affects these scores and has been experienced by many hospital systems

5. Other Reviews: None

6. Outcomes: The Quality Committee will be in a position to report to the Board on the current state as of Q2.

List of Attachments:

1. Q2 STEEEP dashboard

Suggested Committee Discussion Questions:

1. Are there any questions regarding the "red" metrics?
2. What recommendations does the committee have regarding how much information should be delivered to the Board to accompany the dashboard?
3. Would the Committee like to use findings on this dashboard to drive agenda items for more in depth reviews going forward?
4. What additional supporting information would be useful to the Committee to assist in evaluating the metrics?
5. What educational support might be useful to convey to the Board to help with interpretation of this information?

Quarterly Board Quality Dashboard (STEEEP Dashboard) FYTD 21, Q2 (unless otherwise specified by *)

Quality Domain	Metric	Baseline	Target	Performance				
		FY 20	FY 21	FYTD21, Q1	FYTD21, Q2	FYTD21, Q3	FYTD21, Q4	FYTD21 Total
Safe Care	Risk Adjusted Mortality Index	0.74	0.76	0.75	0.79			0.77
	Sepsis Mortality Index	0.96	0.90	0.76	1.14			0.98
	Serious Safety Events Rate (SSER) (baseline Dec'19 to Jun'20)	4.28	4.00	3.98	**3.87			3.87
	Surgical Site Infections (SSI)	0.36	1.0 (SIR)	0.62	0.12			0.37
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	0.47	<= 0.48	0.51	0.71			0.51
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.15	<= 0.2	0.0	0.71			0.2
	Clostridium Difficile Infection (CDI) - HAI	1.46	<= 1.46	1.6	1.44			1.52
	Modified PSI-90 CMS HAC Reduction Program	0.919	0.90	0.898	0.815			0.857
Timely	Patient Throughput - ED Door to Admit Order	190 min	181 min	188 min	197 min			193 min
	Patient Throughput - Median Time Arrival to ED Departure	284 min	245 min	255 min	274 min			265 min
	ED Arrival to Direct Discharge for ED Patients	151 min	145 min	152 min	154 min			153 min
Effective	Risk Adjusted Readmissions Index	0.96	0.93	0.88	*0.90			0.89
	CMS SEP-1 Compliance Rate	70.9%	86%	67.6%	81.8%			75.6%
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	ENT: 1.3%	1.3%	1.4% (1/71)	*1.89% (1/53)			1.6%
	PC-02 NTSV C-Section	ENT: 24.0%	23.5%	27.6% (142/514)	*25.5% (85/333)			26.8%
	ECMN: CMS 165 Controlling High Blood Pressure	51.20%	63	58.0%	56.0%			57.0%
	ECMN: CMS 122 Diabetes Hemoglobin A1c Poor Control	43.30%	<45	26.0%	29.0%			28.0%
	HEDIS: Composite	NA	3.0	3.25	3.3			3.3
Efficient	Arithmetic Observed LOS/ Geometric Expected LOS	1.32	1.00	1.32	1.32			1.32
	MSPB-1 Medicare Spending per Beneficiary (CMS)	0.99 (CY 18)	0.99	0.99	None updated annually, January			0.99
Equitable	Hospital Charity Care Support	$20.5 mil	NA	$6.6 mil	$5.7 mil			$12.3 mil
	Clinic Charity Care Support	$44.3k	NA	$8.5k	1.1k			9.6k
	Language Line Unmet Requests (data collection started Q2)	0.34%	<1%	0.39%	0.64%			0.52%
	Length of Stay Disparity (Top 3 races) 40% patients did not report their race	Black: 4.05	NA	3.98	4.56			4.25
		White: 3.79		3.81	3.97			3.89
		Asian: 3.64		3.54	3.38			3.47
Patient-centered	IP Enterprise - HCAHPS Likelihood to Recommend	83.1	83.6	80.7	78.6			79.5
	ED - HCAHPS Likelihood to Recommend	75.7	78.2	73.9	78.7			76.5
	ECHMN - HCAHPS Likelihood to Recommend	73.2	75.7	76.2	76.0			76.1
	MCH - HCAHPS Likelihood to Recommend	84.1	84.6	82.9	78.2			80.5
	OAS - HCAHPS Likelihood to Recommend	84.7	86.4	83.5	86.1			84.9
	NRC Net Promoter Score (NPS)	72.3	75	76.2	75.7			76.0

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: February 1, 2021
Subject: Health Equity

Purpose: Health Equity has been introduced into the enterprise quality definition represented by STEEEP. (Safe, Timely, Effective, Efficient, Equitable, Person centered care). The purpose of this agenda item is to build on the previous introductory discussion with the committee regarding the role of El Camino Health in this area.

Summary:

1. Situation: One of the key components of the STEEEP definition of quality is equitable care. Health Equity is a complex topic despite the simple definition: "Everyone has a fair opportunity to attain their full health potential." In the Quality Committee self-assessment there was interest expressed regarding more attention to this topic. This topic was introduced at a previous Board QC meeting which concluded with a request to revisit it during this meeting.

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: Health Equity means different things to different people. As a reminder, the definition of health equity along with related topics including health disparity, health inequity, healthcare disparity, social determinants of health, population health, and intersectionality are included in the attachment.

4. Assessment: A review of the demographics of our service area revealed that our population is very diverse but also economically advantaged. (Santa Clara County, for example, has the highest household median income in CA and 5th highest in the U.S.) A summary of our COVID patient demographics and outcomes was compiled to review to look for any disparities that might be identified for corrective action. While we have seen a shift to a younger population of patients hospitalized with COVID, age continues to be a significant risk factor above all other demographical categories. The percentage of COVID patients by race and ethnicity is fairly proportionate to all hospitalized patients as a base for comparison with the exception of the "other" category which shows a three-fold greater percentage by comparison. This demonstrates one of the challenges of using race and/or ethnicity in a very diverse community as the number of mixed marriage offspring cannot be categorized and more and more people refuse to identify their race/ethnicity. The deaths from COVID, however, do appear to line up closely with the overall patient population percentages. From this limited information, we have not demonstrated any healthcare disparity in our patient population.

Because of the high concentration of unaffordable housing in our service area, many of our employees are forced to live far outside our service area in communities that may be less advantaged. Keeping this in mind, as we reviewed our employee vaccination rate we noticed a significantly lower rate among our Environmental Services Employees. This group of employees are lower wage earners and have a higher rate of Hispanic ethnicity. We then engaged this group by arranging for special education sessions with both one of our Infectious Disease specialists accompanied by a Spanish translator. Following this intervention, the vaccination rates increased

and then more closely matched our general employee rate. This demonstrated the need to tailor health messaging to different groups rather than relying on one size fits all. It also confirmed that language is a crucial component of this communication.

Another tool to assess the Social Determinants of Health which impact health equity is the CA Healthy Places Index (HPI). This index is based on 25 community factors that are compiled and used to calculate a score from 0 – 100. Healthcare is a very small component which is no surprise of course. Reviewing the indices we see that our service area has an incredibly high HPI.

5. Other Reviews: None

6. Outcomes: We have not been able to identify any disparities in hospitalized care of our COVID patients. Based on HPI we are serving an affluent community from a health equity point of view. However, outside our service area there is a definite need and this includes some of our own employees who live in those less advantaged areas which means we can at least look within our own walls before extending our reach to those other communities.

List of Attachments:

1. Background material to pre-read to facilitate the discussion.

Suggested Committee Discussion Questions:

Does this information raise any concerns?
Is this information helpful to better understand the complexities of health equity?
How should we handle the growing number of "other" category?
Any suggestions for further study?

El Camino Health

Health Equity

Mark Adams, CMO

February 1, 2021

Agenda

Definitions

Inclusion--Diversity, Equity and Belonging Committee (I-DEB)

Analysis of COVID patient demographics

Case Study Example: Addressing internal healthcare disparity

CA Healthy Places Index

Definitions

Health Equity: Everyone has a fair opportunity to attain their full health potential

Health Disparity: difference in health outcomes between groups within a population

Health Inequity: differences in health outcomes that are systematic, avoidable, and unjust

Health care disparity: racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention

Definitions

Social Determinants of Health: the circumstances in which people are born, grow up, live, work, and age, and the systems put in place to deal with illness

Population Health: the health outcomes of a group of individuals, including the distribution of such outcomes within the group

Intersectionality: multiple social identities such as race, gender, socioeconomic status, and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression

Diversity, Equity and Belonging Committee

Mission Statement:

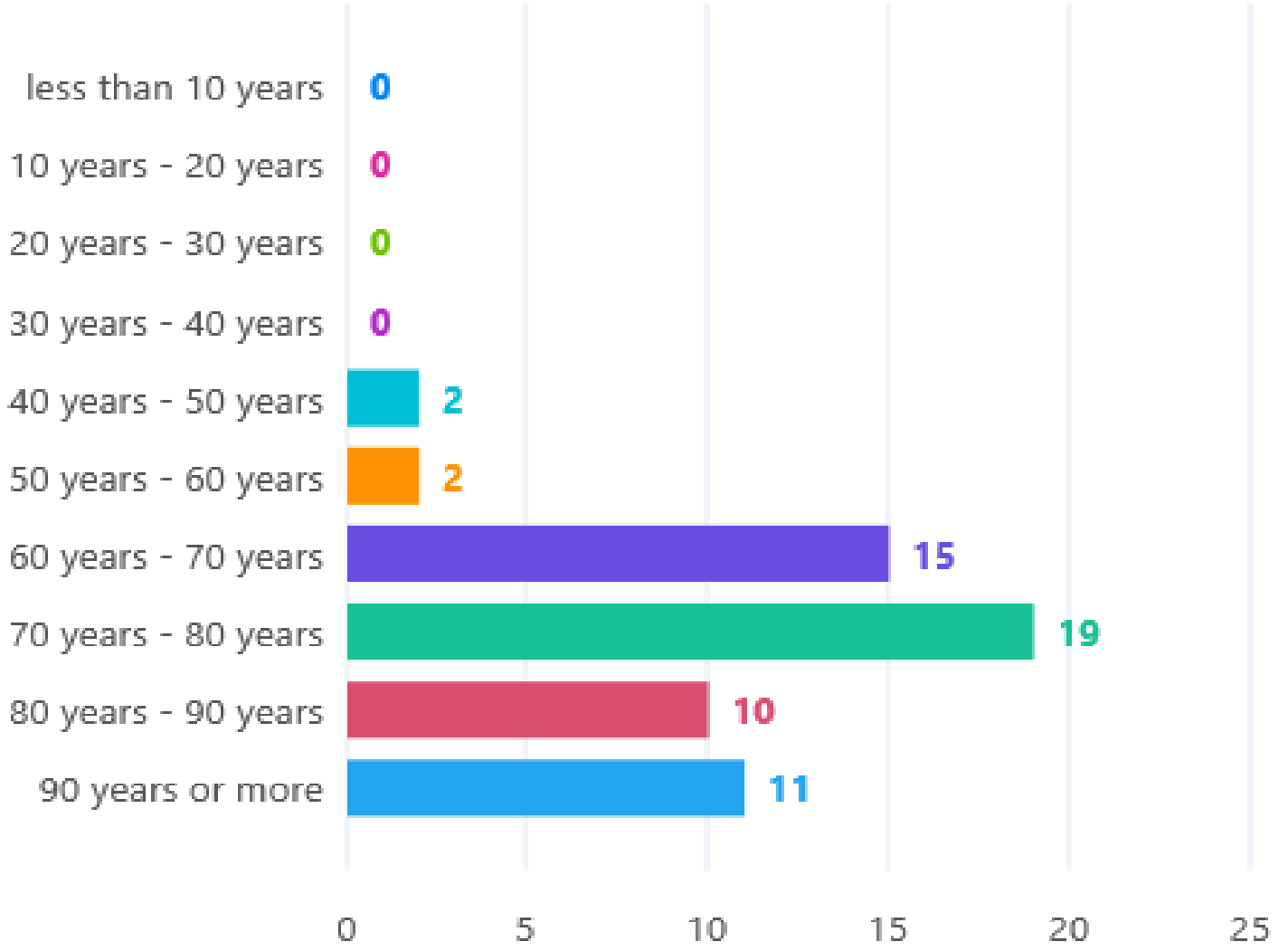
"Our mission at El Camino Health is to be free of bias barriers that separate or disconnect people. Our goal is to create an environment that unites us as human beings, regardless of sex, color, age, dis/abilities or beliefs. We are committed to building a diverse and inclusive community by listening carefully to the shy and the outspoken voices, to be non-judgmental, respectful, compassionate, understanding, and sensitive to the human experience."

Diversity, Equity and Belonging Committee

Responsibilities:

- Identify D&I best practices supported by research.
- Employee engagement: review employee feedback on organizational climate and culture, create opportunities to meaningfully engage, promote cultural inclusivity, discuss issues relating to workplace equity, and strategies to meet patient, community, and workforce needs.
- Patient care: developing cultural competence and responsiveness
- Review of policies and practices impacting diversity, inclusivity, and equity efforts
- Professional development opportunities to deepen understanding of inclusion and equity.
- D&I education/ training and communications across the organization.
- Conduct assessments on effectiveness, accomplishments, and responsibilities, including challenges and barriers, and provide recommendations for interventions and solutions.

COVID Deceased by Age - SlicerDicer



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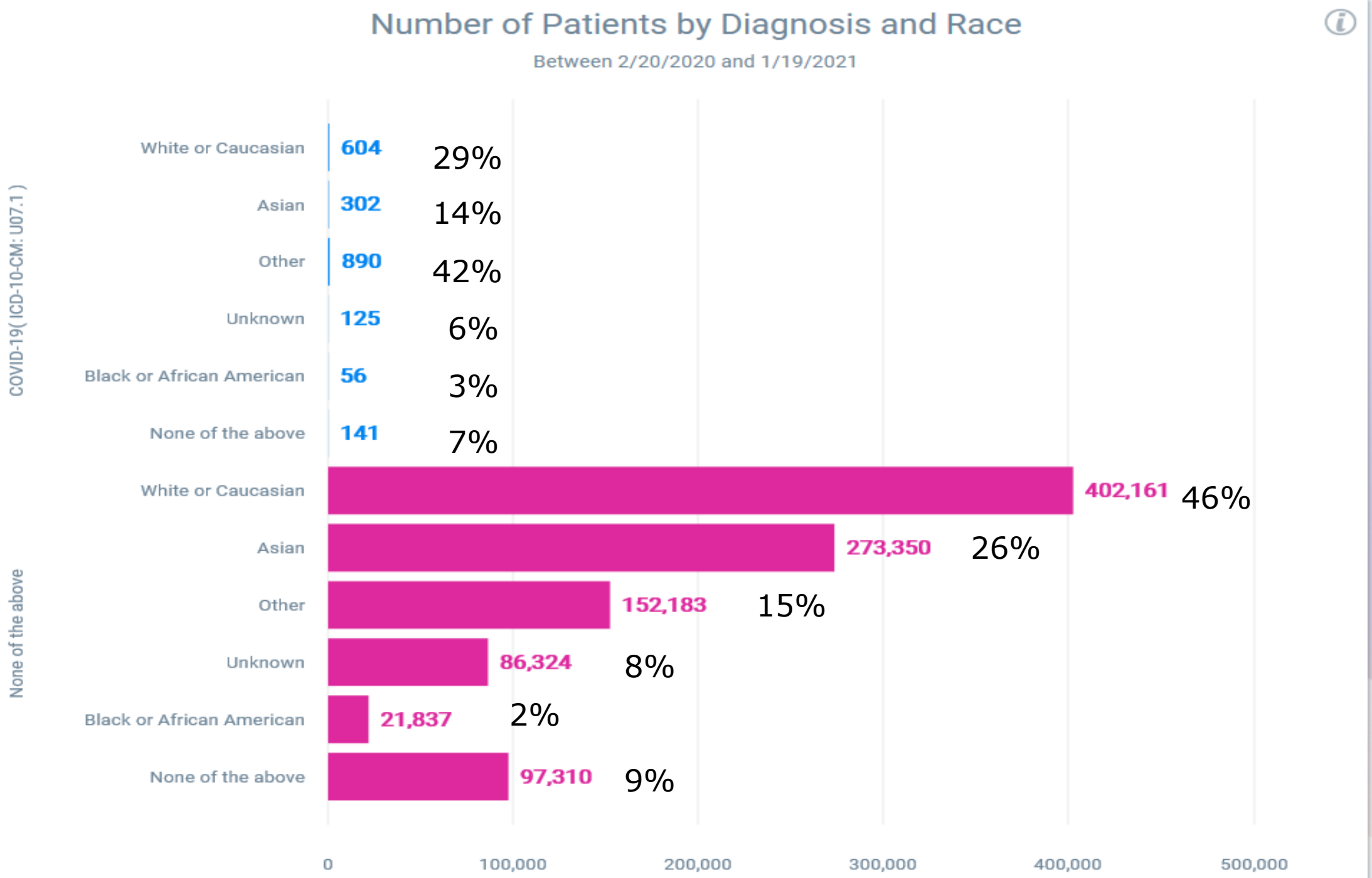
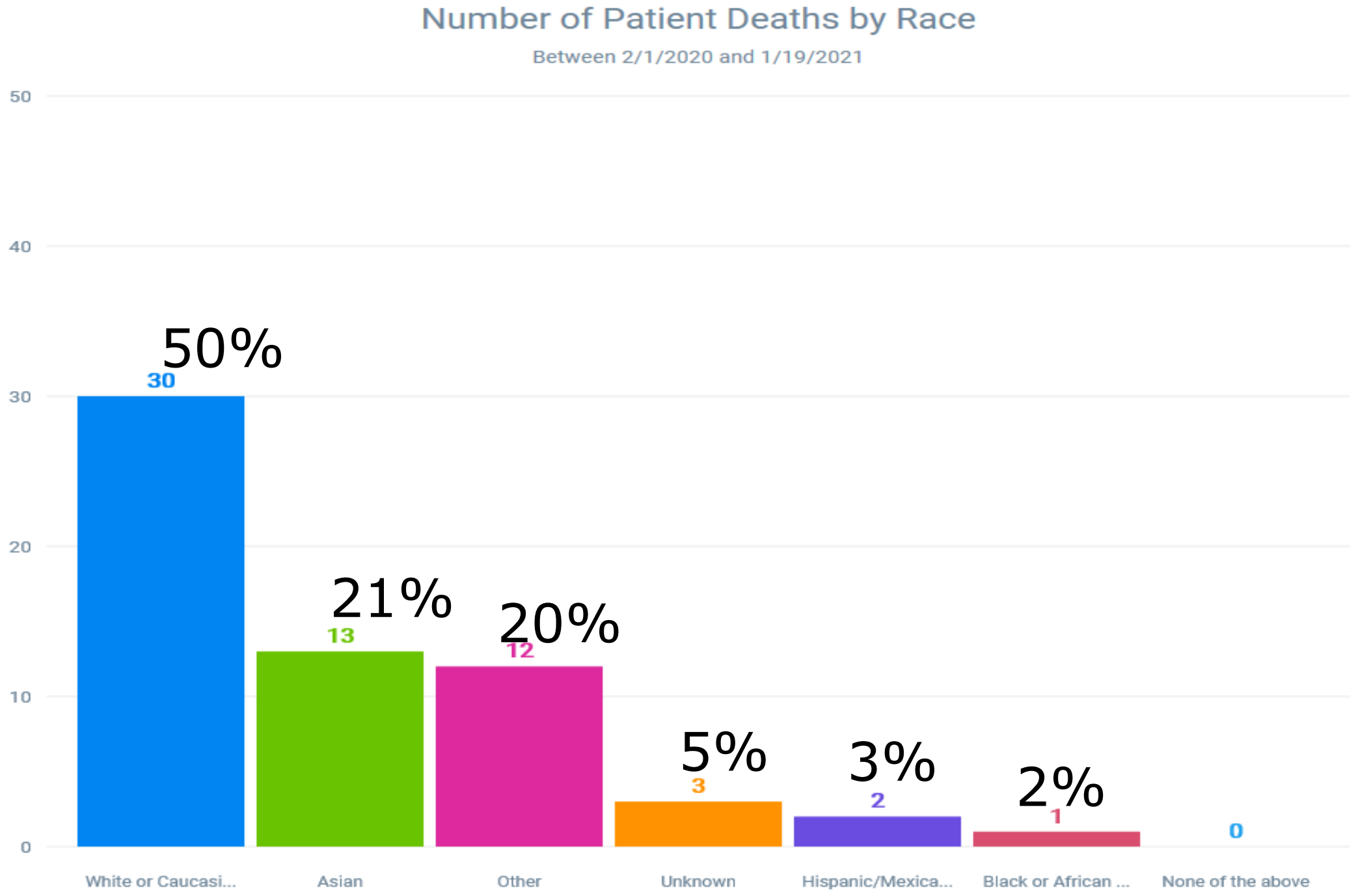
Age as a risk factor

- The data showing the higher risk of death from COVID in the upper age brackets reinforces our approach of vaccinating those age groups preferentially which is consistent with CDC and CDPH guidelines.


Number of Patients by Diagnosis and Race
Between 2/20/2020 and 1/19/2021
COVID-19(ICD-10-CM: U07.1)
White or Caucasian
604
29%
Asian
302
14%
Other
890
42%
Unknown
125
6%
Black or African American
56
3%
None of the above
141
7%
None of the above
White or Caucasian
402,161
46%
Asian
273,350
26%
Other
152,183
15%
Unknown
86,324
8%
Black or African American
21,837
2%
None of the above
97,310
9%
0
100,000
200,000
300,000
400,000
500,000


Number of Patient Deaths by Race
Between 2/1/2020 and 1/19/2021
50
40
30
20
10
0
50%
30
21%
13
20%
12
5%
3
3%
2
2%
1
0
White or Caucasi...
Asian
Other
Unknown
Hispanic/Mexica...
Black or African ...
None of the above

Addressing equity internally

Upon reviewing employee vaccination data, the following stood out:

- Environmental Services MV: 48%
- Environmental Services LG: 38%

Principles of Social Determinants of Health considered and this group recognized as skewed by race, ethnicity, socioecomic status, and language

Addressing equity internally

Intervention: Organize a series of meetings with the environmental services employees and Dr. Shin to provide support for vaccine benefits and allow concerns and questions to be directly addressed. Augment these meetings with real-time Spanish speaking translator.

Follow up vaccination rates:

Environmental Services MV: 75%

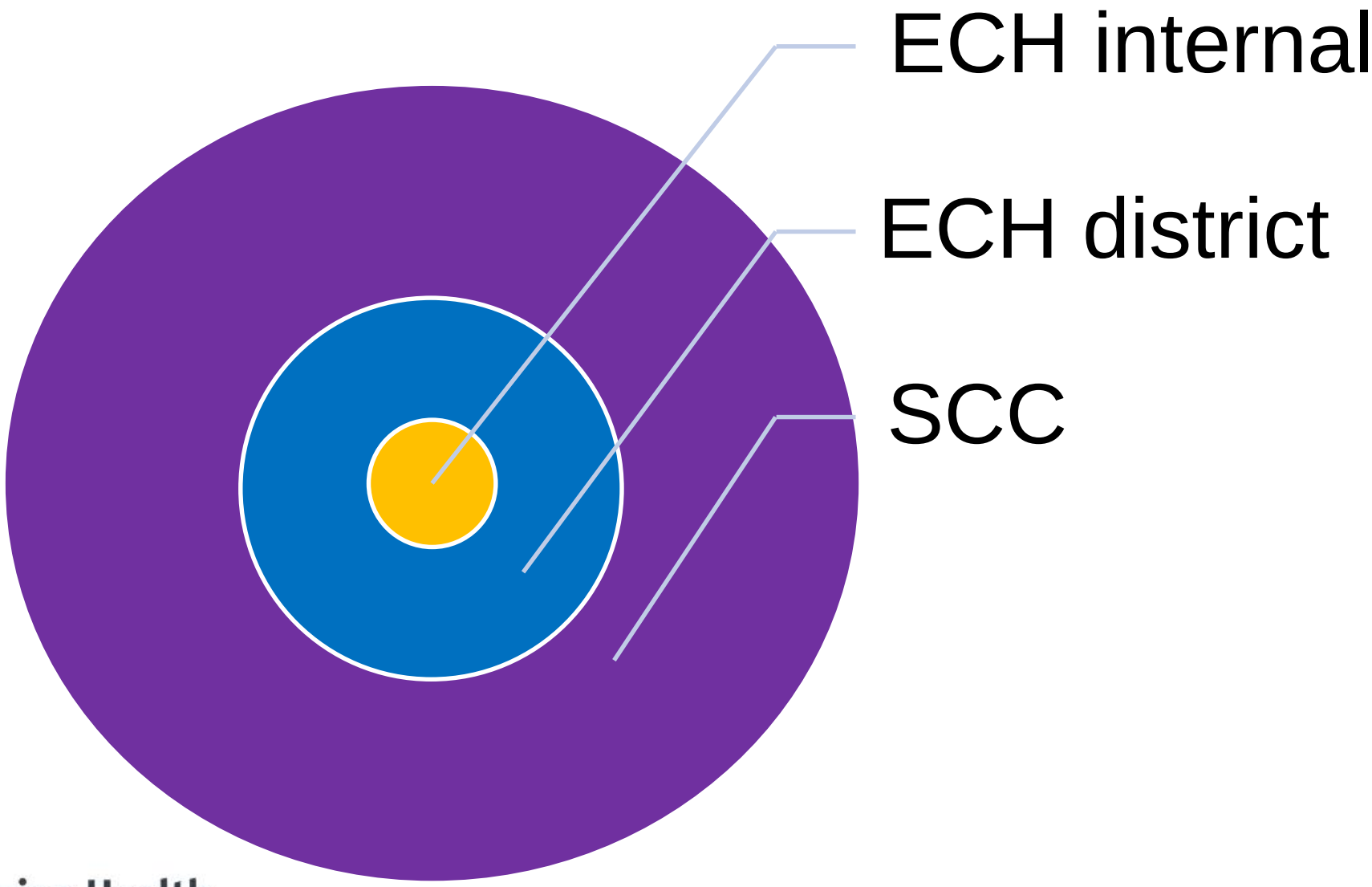
Environmental Services LG: 69%

Addressing equity internally

Lessons learned:

1. Review results in a health equity context
2. Understand the barriers
3. Avoid assumptions
4. Take action
5. Be prepared for surprises—don’t know what we don’t know

Equity Concentric Circles of Influence



The California Health Places Index (HPI)

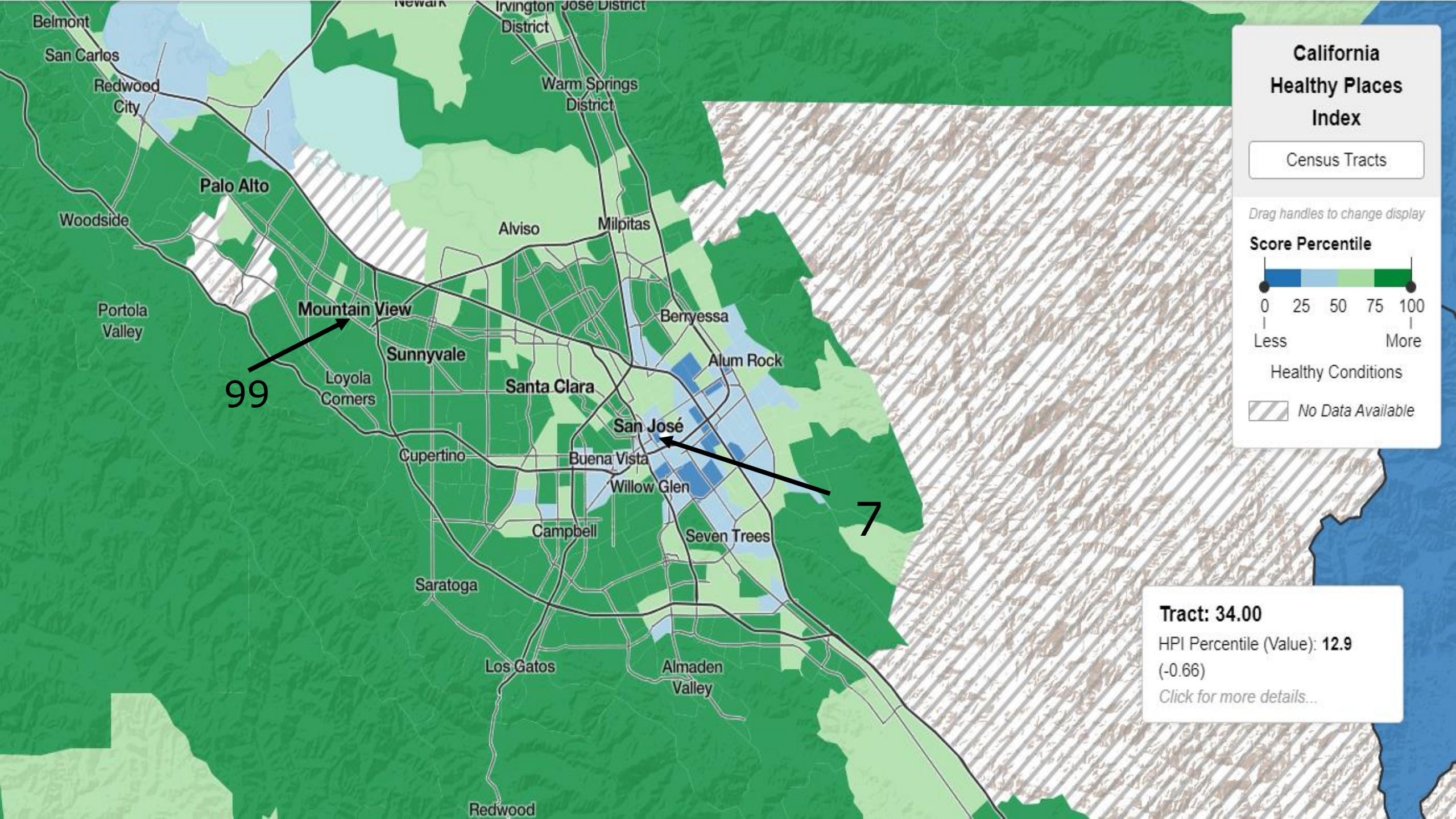
- The HPI combines 25 community characteristics into a single indexed HPI Score

El Camino Health

HPI Components

Action Areas	Economic	Social	Education	Transportation	Neighborhood	Housing	Clean Environment	Healthcare
Weight (fraction)	.32	.10	.19	.16	.08	.05	.05	.05
Indicators	Employed	Two Parent Households	In Preschool	Automobile Access	Retail Density	Low-Income Renter (Severe Housing Cost Burden)	Ozone	Insured
	Income	Voting in 2012	In High School	Active Commuting	Park Access	Low-Income Homeowner (Severe Housing Cost Burden)	PM 2.5	
			Bachelor's Education or Higher		Tree Canopy	Housing Habitability	Diesel PM	
					Supermarket Access	Uncrowded Housing	Water Contaminants	
					Alcohol Outlets	Homeownership		

El Camino Health


Belmont
San Carlos
Redwood City
Palo Alto
Woodside
Portola Valley
Mountain View
Sunnyvale
Loyola Corners
Santa Clara
Alviso
Milpitas
Berryessa
Alum Rock
San José
Cupertino
Buena Vista
Willow Glen
Campbell
Seven Trees
Saratoga
Los Gatos
Almaden Valley
Redwood
Irvington District
Warm Springs District
99
7
California Healthy Places Index
Census Tracts
Drag handles to change display
Score Percentile
0 25 50 75 100
Less
More
Healthy Conditions
No Data Available
Tract: 34.00
HPI Percentile (Value): 12.9
(-0.66)
Click for more details...

Health Equity

Assessment:

- We can have a direct impact on our own employees and patients
- Our service area is very privileged when considering the Social Determinants of Health (SDOH)
- Some of the greatest need is beyond our primary service area