El Camino Health

AGENDA

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

Monday, April 5, 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.* ***Approval*** a. Minutes of the Open Session of the Quality Committee Meeting (03/01/2021) ***Information*** b. Progress Against FY21 Committee Goals c. FY21 Enterprise Quality Dashboard d. Report on Board Actions e. Quality Committee Follow-Up Tracking	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:34**
4.	**CHAIR'S REPORT**	Julie Kliger, Quality Committee Chair		**information 5:34 – 5:39**
5.	**PATIENT STORY** **ATTACHMENT 5**	Cheryl Reinking, RN, CNO		**information 5:30 – 5:44**
6.	**PATIENT EXPERIENCE (HCAHPS)** **ATTACHMENT 6**	Cheryl Reinking, RN, CNO		**discussion 5:44 – 5:49**
7.	**COVID IMPACT ON MORTALITY AND READMISSION** **ATTACHMENT 7**	Mark Adams, MD, CMO		**discussion 5:49 – 5:59**
8.	**PROPOSED FY22 MEETING DATE** **ATTACHMENT 8**	Mark Adams, MD, CMO	*public comment*	**possible motion 5:59 – 6:04**
9.	**PROPOSED FY22 STRATEGIC GOALS** **ATTACHMENT 9**	Mark Adams, MD, CMO		**discussion 6:04 – 6:24**
10.	**APPROVE FY22 COMMITTEE GOALS** **ATTACHMENT 10**	Mark Adams, MD, CMO	*public comment*	**possible motion 6:24 – 6:34**

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.	**VALUE BASED PURCHASING REPORT** **ATTACHMENT 11**	Mark Adams, MD, CMO		**discussion** **6:34 – 6:49**
12.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information** **6:49 – 6:52**
13.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required** **6:52 – 6:53**
14.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information** **6:53 – 6:54**
15.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair		**motion required** **6:54 – 6:55**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (03/01/2021) ***Information*** b. Quality Council Minutes			
16.	*Health and Safety Code Section 32155* **MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, CMO		**motion required** **6:55 – 7:05**
17.	*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** **7:05 – 7:10**
18.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required** **7:10 – 7:11**
19.	**RECONVENE OPEN SESSION/ REPORT OUT**	Julie Kliger, Quality Committee Chair		**information** **7:11 – 7:12**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
20.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion** **7:12 – 7:17**
21.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required** **7:17 – 7:18**

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, March 1, 2021
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Julie Kliger, Chair**
George O. Ting, MD, Vice Chair**
Melora Simon**
Krutica Sharma, MD**
Terrigal Burn, MD**
Michael Kan, MD**
Apurva Marfatia, MD**
Jack Po, MD**
Alyson Falwell**

Members Absent

****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. Melora Simon was not present during roll call. 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 the Quality Dashboard for discussion. She wanted to expand and discuss the readmission and mortality as it's trending higher than normal. Dr. Adams explained that the 12 month rolling trend graph shows the change over time. In December, there was a spike in readmissions due to COVID which continued through January. He predicted January would be similar due to COVID patients. In terms of Fiscal Year to Date, readmission index is still on target. For mortality, there were many more deaths in December and January than what was experienced before and many are due to COVID. Ms. Reinking stated that the timing issue in the waiting room was partly due to having the standard of testing patients upon arrival. **Motion:** To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (02/01/2021); For information: (b) Progress Against FY21 Committee Goals, (c) FY21 Enterprise Quality Dashboard, (d) Report on Board Actions, and (e) Quality Committee Follow-Up Tracking **Movant:** Burn **Second:** Simon **Ayes:** Burn, Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, & Ting **Noes:** None **Abstentions:** None **Absent:** None **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 patient was here during the surge in January. The letter talked about what we hope happens with all patients; that the staff was compassionate and provided updates, etc. Ms. Reinking stated that the patient came to the hospital from an urgent care and was immediately placed in a room. When the patient got to the cardiology unit, care was explained by the physician and what the treatment plan would be. The patient was also very complimentary of the food and identified one nurse, Marcella, who went above and beyond in explaining everything throughout the entire course of stay. With that being said, Ms. Reinking announced the nomination of Marcella for The Daisy Award because of her excellence.	
6. PROPOSED FY22 COMMITTEE GOALS	Mark Adams, MD, CMO, presented the Proposed FY22 Committee Goals. He wanted to see what the committee might want to add or subtract from this. He suggested for #2 that perhaps the addition of education regarding Ongoing Professional Practice Review (OPPE) and Focused Professional Practice Review (FPPE) be added. Chair Kliger supported that suggestion. She also stated that Goal #5 is an area or opportunity to be more interactive and collaborative to opine on different topics. She also reiterated what Dr. Adams suggested in removing items driven by regulatory, not so important items, or discussion topics and to put them in the consent calendar to make room to brainstorm for more important items.	
7. UPDATE ON LEAN TRANSFORMATION	Dr. Adams presented the Update on LEAN Transformation. He stated that there is a Lean Steering Committee that reports to Jim Griffith, COO. Dr. Adams presented some examples of some of the work being monitored by the steering committee. This included efforts to improve OR on time starts and ED throughput. Lastly, Dr. Adams stated that LEAN methodology was used to quickly stand up a vaccination program for the public. In response to committee members' questions, Dr. Adams stated that high reliability depended on not only people understanding the process, but to simplify the processes to eliminate waste and extra steps. Dr. Adams stated that he wanted to reduce errors through high reliability. Dr. Adams also stated that the hospital had increased rounding. Visitors are still not allowed at the moment and because of that, it allowed staff to focus more on the patients.	
8. PROGRESS ON QUALITY AND SAFETY PLAN	Dr. Adams presented the Progress on Quality and Safety Plan. He stated that this plan gets revised on a yearly basis and preparation for the next QAPI plan for FY22 is underway. Management wanted to make sure that the strategic plan gets integrated with the QAPI plan. Dr. Adams stated he wanted to focus on the areas that were noted as incomplete. Out of all of the ones listed in the packet, Just Culture needs the most work. In response to committee members' questions, Dr. Adams stated that the Culture and Safety work is never done so it should be corrected and amended to be stated as 'In Progress' instead of 'Complete'. He stated he wanted to also implement a corrective action to minimize human errors. Dr. Adams also stated that a survey will be done in May to assess the organization's Culture of Safety.	

	Chair Kliger suggested getting ideas and recommendations from the Quality Committee on how communications could be enhanced to the Board on Quality and putting this on the pacing plan for a discussion item. Jack Po, MD, PhD, commented that he was conflicted regarding the notation around 'Board communication on Quality and wishing the board would spend more time on it' due to the board still having to figure out a strategy and roadmap and also the Quality Committee neglecting on talking about patient experience not only on the inpatient side, but also on the outpatient side. Chair Kliger also suggested another agenda item around how to expand the discussions generally to be broader and to represent the true nature. Melora Simon suggested an agenda item on Patient Safety Pareto Analysis to understand the degree of what's been internalized and what the big drivers are, etc.	
9. PUBLIC COMMUNICATION	There was no public communication.	
10. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 6:42pm. **Movant:** Po **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 6:42pm***
11. AGENDA ITEM 16: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:10pm. Agenda items 11-16 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (02/01/2021), Quality Council Minutes, and Medical Staff Credentialing and Privileges Report.	
12. AGENDA ITEM 17: CLOSING WRAP UP	Dr. Kan announced that Los Gatos was rated by Mosley Magazine as one of the top hospitals in the nation in maternity hospitals being the only private hospital in the San Francisco Bay Area named as maternity hospitals.	
13. AGENDA ITEM 18: ADJOURNMENT	**Motion:** To adjourn at 7:13pm. **Movant:** Burn **Second:** Falwell **Ayes:** Burn, Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Meeting adjourned at 7:13pm***

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

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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: Catherine Carson, MPA, BSN, CPHQ, Sr. Director Quality
Date: April 5, 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 increased in December and January above target due to high volume of readmissions: 115 in December, 118 in January
- **B.** 2 SSEs assigned by team review for December: 1 SSI and 1 HAPI
- **C.** Mortality Index increased to 1.12 , with 38% dying on day 1 or 2 of hospitalization
- **D.** HCAHPS Likelihood to Recommend is impacted by continued visitor limitations.
- **E.** 2 C.Diff HAIs for January due to patients with history of C.Diff requiring multiple antibiotics.
- **F.** Zero Surgical Site Infections in February 2021
- **G.** Sepsis mortality Index up again in February with 54% deaths due to Sepsis. Expected value lower than January due to documentation.
- **H.** PC-01 at zero, with prospective oversight by medical director
- **I.** PC-02, Cesarean Birth above target, OB Task force trending providers and reviewing cases
- **J.** Patient Throughput down for the first time in months with strategies to move patients out of ED./

  See additional detailed comments in the annotation of the report

5. Other Reviews: None

6. Outcomes: N/A

Suggested Committee Discussion Questions: None

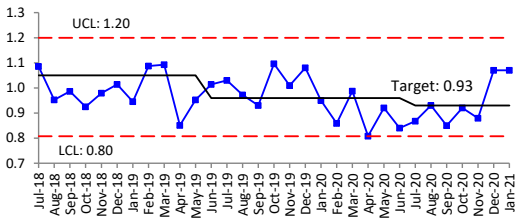
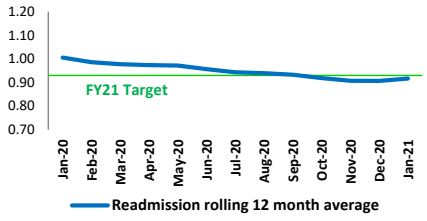
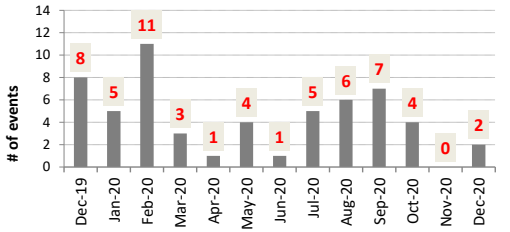
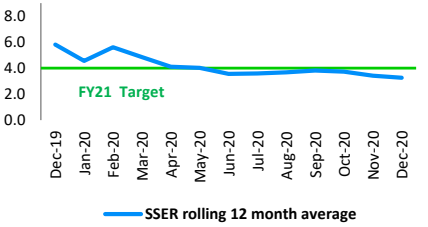
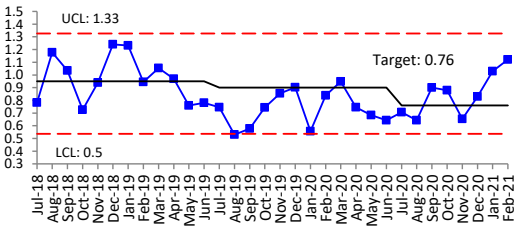
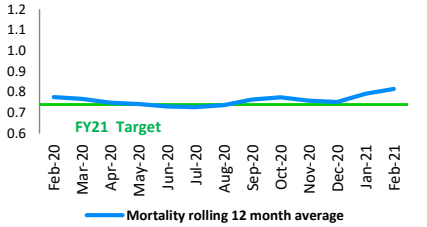
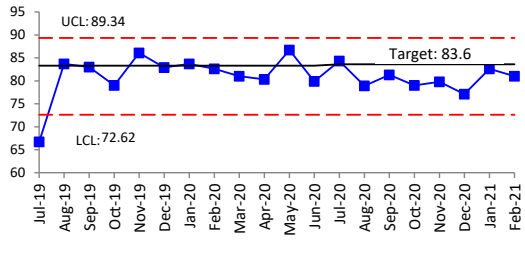
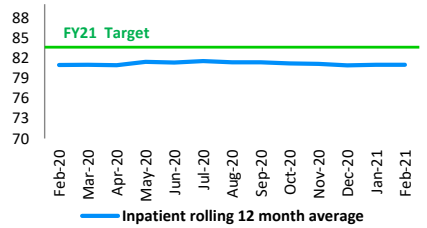
List of Attachments: April 2021 Enterprise Quality, Safety, and Experience Dashboard, March data unless otherwise specified - final results

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

March 2021 (unless otherwise specified)

Month to Board Quality Committee:
April, 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: January 2021*	1.07 (8.81%/8.24%)	0.94 (7.76%/8.22%)	0.96	0.93		
2	*Organizational Goal **Serious Safety Event Rate (SSER)** # of events/ (FYTD Rate per 10,000 Acute Adjusted Patient Days) ****Latest data month: December 2020*	2	3.35 (57/170173)	4.28	4.0		
3	* Strategic Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: February 2021*	1.12 (2.48%/2.21%)	0.86 (2.01%/2.35%)	0.74	0.76		
4	*Organizational Goal **IP Enterprise - HCAHPS Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: February 2021*	81.0	80.1	83.1	83.6		

Definitions and Additional Information

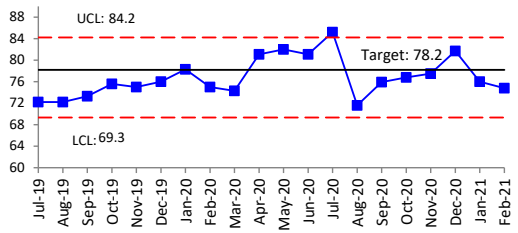
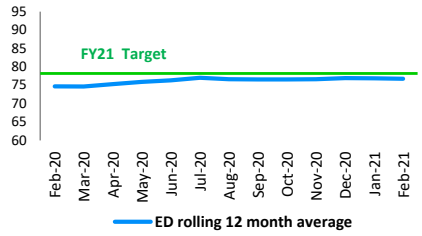
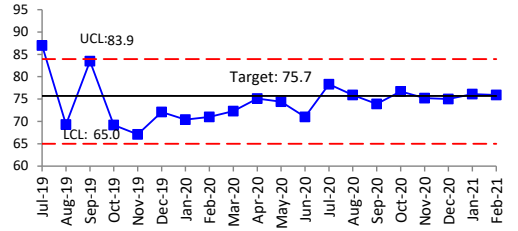
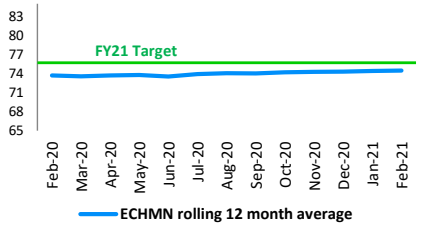
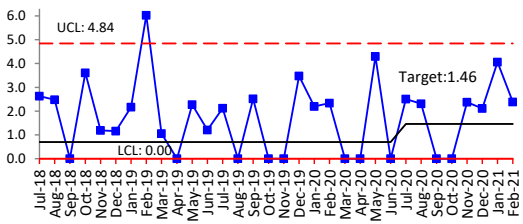
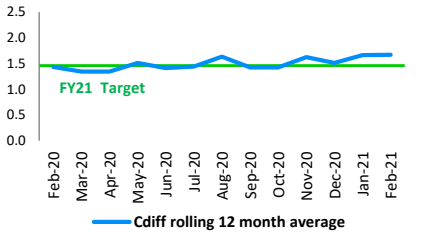
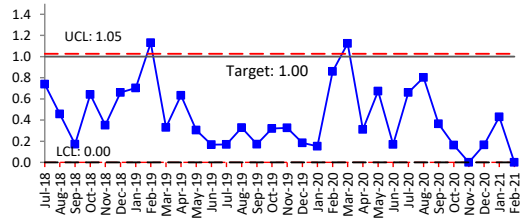
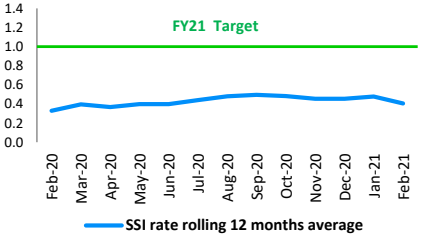
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
1. Readmission Index - All Patient All Cause Readmit (Observed/Expected)	Readmissons Index and total # of readmissions is up again; after 86 in November, we had 115 in December and 118 in January. A review of the patients readmitted revealed: 17 readmissions for Sepsis, 10 readmissions due to alcohol withdraw/cirrhosis, 7 due to COVID, and 6 due to readmissions related to pregnancy and for delivery.	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)	2 SSE's for December: 1- Surgical Site Infection and 1 Hospital-acquired Pressure Ulcer Stage 3.	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)	Mortaity Index has increased since November. With 39 deaths in February, 21 or 54% were due to Sepsis, 7 due to COVID. 15 patients or 38% died on the first or second day of hospitalization.	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	While the visitation policy (i.e. no visitors) is still in effect, we have been focusing on proven best practices in the inpatient area for LTR (likelihood to recommend). The 'trifecta' as it's called, includes nurse leader rounding, purposeful rounding (hourly) and bedside shift report. This is a focused area for improvement for all patients across the enterprise as it provides improved communication and continuity of care. Our clinical leaders continue to ensure these best practices are hard wired into daily work. In addition, we have increased the cadence of our leader rounding and executive rounding to ensure more presence with patients and staff.	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

March 2021 (unless otherwise specified)

Month to Board Quality Committee:
April, 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: February 2021*	74.8	76.2	75.7	78.2		
6	* Organizational Goal **ECH MD : Likelihood to Recommend Care Provider** (SVMD only) **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: February 2021*	75.9	75.9	73.2	75.7		
7	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Latest data month: February 2021*	2.39 (2/8377)	1.97 (14/71075)	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: February 2021*	0.00 (0/325)	0.34 (15/4372)	0.36	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

Definitions and Additional Information

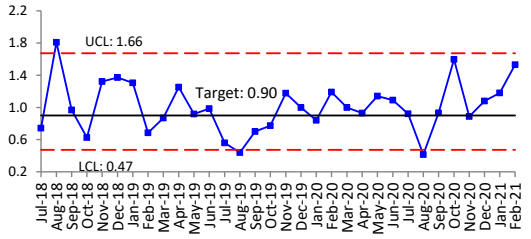
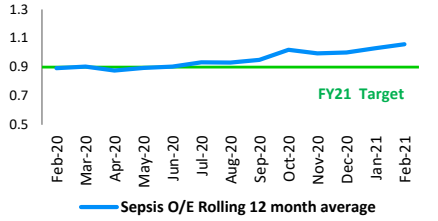
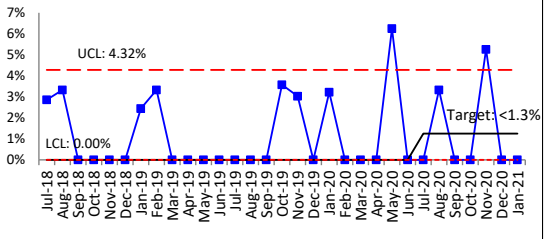
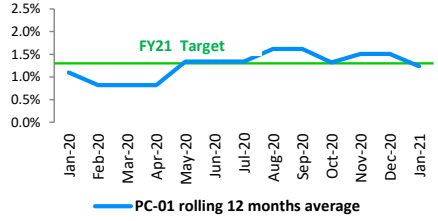
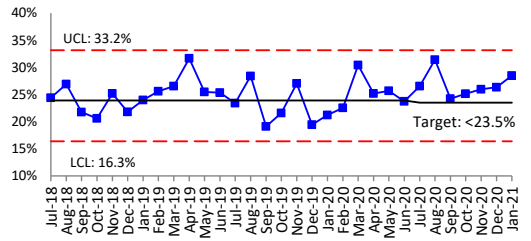
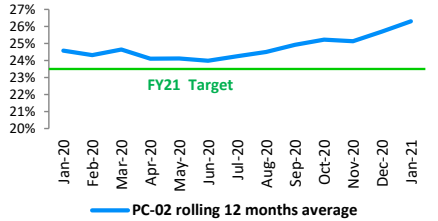
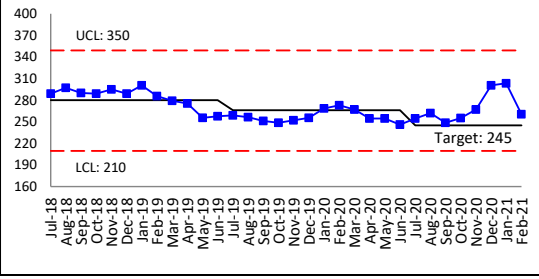
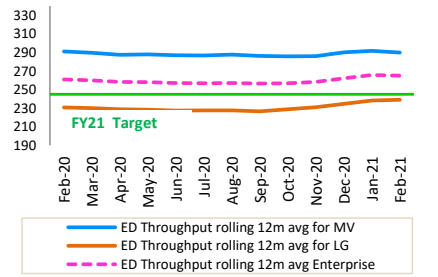
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
5. ED - Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted	Despite an increase over the past 12 months, both Mountain View and Los Gatos ED's are below target due to the increased demands of the pandemic. The visitor policy was updated in February to allow for one support person to enter and assist with each patient. A focus on teamwork continues as this is a key driver for LTR (likelihood to recommend). This includes ensuring consistency with our bedside shift report and communicating our transitions from staff to staff. In addition, we have put plans in place to increase our nurse leader rounding and we are working on ensuring that patients are updated about their wait time (we know that patients under the age of 50 waiting more than 3.5 hours score us the lowest).	Christine Cunningham	Likelihood to Recommend - PressGaney data (not part of HCAHPS) 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 SVMD Clinics continue to exceed target for FY21. Work continues to be focused on WeCare elements such as rounding, recognition, and enforcement of our standards of behaviors.	Christine Cunningham	ECHMD – does not have HCAHPS – we use only one data point that is NPS (net promotor score), which is a likelihood to recommend care provider (SVMD only) 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 HAI C.Diff in February: 1 in MV: 61 y/o admitted with fever, mailaise, fatique, CT of abdomen: concern for colitis. C.Diff expected after multiple doses of antibiotic. 1 in LG:86 y/o admitted from home with recurrent and chronic UTI. Prolonged antibiotic use at home for chronic UTI, and new antibiotic use in hospital.	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	Zero SSI in February. OR staff educaiton on surgical preps finished in February.	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

March 2021 (unless otherwise specified)

Month to Board Quality Committee:
April, 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: February 2021*	1.53 (17.59%/11.50%)	1.07 (13.37%/12.52%)	0.98	0.90		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) *******Latest data month: January 2021*	MV: 0.0% (0/29) LG: 0.0% (0/8) **ENT: 0.0%** (0/37)	MV: 0.7% (1/148) LG: 2.2% (1/45) **ENT: 1.04%** (2/193)	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: January 2021*	MV: 27.0% (31/115) LG: 32.6% (14/43) **ENT: 28.5%** (45/158)	MV: 27.7% (257/928) LG: 23.8% (50/210) **ENT: 27.0%** (307/1138)	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, Newborns)* *Latest data month: February 2021*	MV: 284 min LG: 237 min **Ent: 261 min**	MV: 291 min LG: 248 min **Ent: 270 min**	MV: 304 min LG: 263 min **Ent: 284 min**	MV: 263 min LG: 227 min **Ent: 245 min**		

** PC-01, PC-02 and Readmissions data are available up to January 2021

*** SSER data available up to December, FYTD data displayed as a rate per 10,000 Acute Adjusted Patient Days (EPSI report) for the reporting period of December 2019 to December 2020

Report updated: 3/23/21

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	Sepsis mortality has increased in tandem with overall mortality index. Of the 39 deaths in February, 21 or 54% were due to Sepsis. All Sepsis deaths are reviewed in depth and some are referred for peer reivewi if necessary. Sepsis team has a new Sepsis Dashboard with detailed metrics that include all Sepsis paitents, not only the core measure Sep-1 sample. This dahsbaord in now shared at each Medicine Executive meeting of the medical staff.	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	MCH continues to prospectively track EED and reach out to providers to reschedule as needed. This screening by the medical director continues and is working.	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	Medical Director is unssure of the reason for the increasing trend since September. MCH has added volume with increased deliveries @ LG, but not necessarily midwife patients which has historically provided a buffer for NTSV. There are no known changes to practice, new guidelines, etc. We have not yet instituted any system based approaches as we are working through our IOL management process/procedures and not yet arrived to labor management which is the area where we may be able to target this number. We are due to give provider feedback, data cards now that we have full 2020 out for review.	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	A new definition has been agreed upon that will exclude patient transsfers between LG and MV, but the report has not yet been revised. These data for February use the old definition. The Patient Throughput Value Stream continues to work on stabilizing the electronic SBAR handoff, Capacity Management Center (CMC), and nurse staffing. We have filled the day shift of the PFC role with a traveler and she will cover from March 22nd until end of June 2021. We are piloting an ADT nurse to help with ED throughput from April 5th to June 30th. This position will be filled by two travel nurses Monday to Saturday from 11am – 11:30pm. We are moving forward with Epic enhancements that allow for predictive modeling specifically for patients in the ED and the probability of those patients becoming inpatients.	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, newborns Arrival: Patient Arrived in ED ED Departure: Departed ED *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: April 5, 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 Committee, the Hospital Board has met once and the District Board has met once. 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	March 10, 2021	- Closed Session Quality Committee Report including Credentials and Privileges Report - PBX Operator Scope of Service - Enterprise Mental Health and Addiction Aspire Program Physician Psychiatric Contract with ECMA
ECHD Board	March 16, 2021	- Approved FY21 Period 7 ECHD Consolidated and ECHD Stand-Alone Financials - Elected Don Watters to serve on the El Camino Hospital Board of Directors to fill a vacancy expiring on June so, 2021 and for a new term expiring on July 1, 2024
Executive Compensation Committee	N/A	
Compliance and Audit Committee	N/A	

Report on Board Actions
April 5, 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	

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: April 5, 2021
Subject: Patient Experience Comments

Purpose: To provide the Committee with written patient feedback that is received via the Press Ganey HCAHPS Survey tool.

Summary:

1. Situation: These comments are regarding a patient with experience in trying to receive a COVID test on a Sunday.

2. Authority: To provide insight into one patient's experience in finding the COVID testing site on a Sunday.

3. Background: While the patient's experience with the staff once she was able to find her way to the COVID testing area, she was inconvenienced by not being clear where to go for the test.

4. Assessment: The patient's experience was mixed due to the unfortunate less than clear information for the COVID test. While staff were attempting to help her, the experience was not as smooth as usual due to changes in process for the weekends.

5. Other Reviews: None

6. Outcomes: We investigated this situation and determined that our communication with this patient was not clear. We have changed our process to include a text message through Epic to insure the patient knows where to go on the day of the test. In addition, we have also included e-mail notifications. While we do give patients directions on the phone when we make the appointment. A times these are not written down by the patient and it can be confusing when arriving to the campus.

List of Attachments: Patient Comments

Suggested Committee Discussion Questions:

1. How are you incorporating technology to inform patients about their care at ECH and what to expect?

2. What did you learn from this patient's experience?

Patient Comment from Press Ganey Survey

Re: COVID Testing

I arrived to find the door to the Hospital Drive entrance where I've always entered before locked. I asked the nurse in the drive through for help and she said she could let me in but then there were no masks so she had to go back to the parking lot to get me a mask. Then she walked me to the lab but was told in the lab the drive though Covid testing was supposed to do mine apparently (on Sunday). The nurses in the drive through went out of their way to accommodate me and we got it done but we had to wait for paperwork in the lab to take back to the Drive through so they could correctly mark the test sample. In the end it was all good but it should be clear to patient and testers. Thank you. (Lab)

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: April 5, 2021
Subject: Patient Experience (HCAHPS)

Purpose: To provide the Committee with an update on the patient experience work focusing on the Likelihood to Recommend (LTR) Strategic Goals.

Summary:

1. Situation: The organization has struggled to meet the LTR goals the first six months with the difficulties presented by the pandemic. However, with the surge past, the teams are focusing on the best practices specified in the plan for improvement.

2. Authority: To provide insight into the patient experience improvement work at ECH.

3. Background: The slides will reveal our current performance for the LTR through February. The teams have been meeting and working all fiscal year on the plans, but the surge in Nov, Dec, Jan, and February was distracting because other priorities needed to be attended to during that time by the leaders. In addition, the inability to have visitors has been an ongoing concern for patients. We know and appreciate the contribution loved ones make in the healing and recovery process.

4. Assessment: The LTR scores are mixed, but early signs show the best practices performed with consistency are beginning to show an increase in our LTR performance.

5. Other Reviews: None

6. Outcomes: The teams are working very diligently to achieve the LTR target by the end of the fiscal year using the plans that are proven to produce results.

List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. How are you motivating the teams to perform best practice and other initiatives given they are tired and weary as they have faced the pandemic for over one year now?

2. What other factors influence the LTR scores?

El Camino Health

Quality Committee

Cheryl Reinking, DNP, RN, NEA-BC
Chief Nursing Officer
April 5, 2021

Quality Committee

April 5, 2021

we care

SERVICE

Exceptional, Personalized Experience, Always

SERVICE – True North: Exceptional Personalized Experience, Always

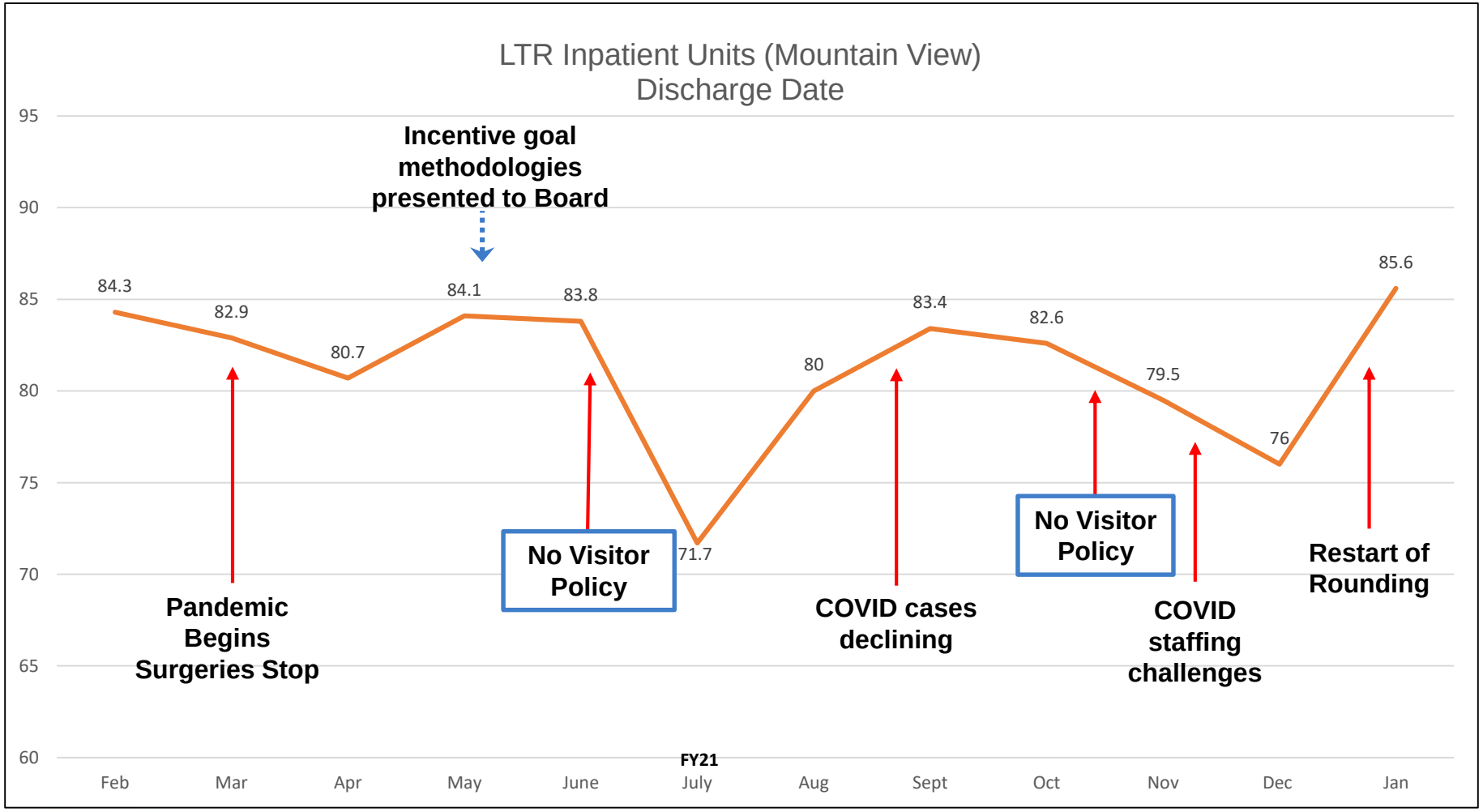
	Organizational Goal	FY2020	FY21 Q1 YTD	FY21 Q2 YTD	FY2021 Target	Desired State
H	**Likelihood to Recommend (LTR) – Inpatient** (Higher is better)	82.5 (85th %ile)	80.7 (82nd %ile)	79.5 (77th %ile)	83.6 (86th %ile)	Top Decile
H	**LTR – Emergency Department** (Higher is better)	77.9 (74th %ile)	73.9 (64th %ile)	76.5 (74th %ile)	78.2 (79th %ile)	Top Quintile
H	**LTR – Inpatient Units** (Higher is better)	82.5 (85th %ile)	79.7 (79th %ile)	79.2 (76th %ile)	83.3 (86th %ile)	Top Decile
H	**LTR – Mother Baby Unit** (Higher is better)	84.3 (90th %ile)	82.9 (87th %ile)	80.5 (80th %ile)	84.6 (90th %ile)	Top Decile

FY2021 Metric Explanation

- **Likelihood to Recommend Inpatient** - While the visitation policy (i.e. no visitors) affects our patient's experience, the temporary cancellation of leader rounding in November and December due to the need to have leaders provide direct patient care negatively impacted the scores as well. The best practice, "nurse leader rounding" and "leader rounding" which historically has improved LTR metric performance (including metrics below) is a focused area for improvement for all patients across the enterprise and has restarted in mid-January. Each unit (including ED, Inpatient, and Mother Baby) has developed a plan to improve their LTR scores, and performance is being reported regularly. Additionally, emphasis around WeCare Excellence Standard behaviors and leader rounding will accelerate in the coming months.
- **LTR Emergency Department** - Both Mountain View and Los Gatos are below our FY21 target despite an increase in the metric over the last 12 months and a positive performance in December (81.7). The lack of visitation also affects this metric. WeCare behavior training and measures in place to address the safety concerns of our ED patients are positively impacting our patient's perception of safety, and in turn affecting our overall score. The activation of a new bedside shift report in ED will specifically address our teamwork metric performance, which is a significant factor in ED LTR performance. Improvements in the physical wait space are in progress, with the intent of improving the environment of care.
- **LTR Inpatient Units** - While 6 units have seen improvements in their scores, 7 have seen a degradation in scores. As mentioned above, each unit has developed a plan and is reporting measurement to plan regularly.
- **LTR Mother Baby Unit –** Los Gatos continues to be above target in this metric. However, Mountain View has struggled with improvement in this area, and is a primary target for accelerating "nurse leader rounding" and "leader rounding" initiatives.

Service - Performance Correlates With Pandemic Related Events

- When LTR performance is viewed by discharge date (rather than received date), declines in performance align with events on the pandemic timeline.



El Camino Health

Service – Management Initiatives to Address Patient Experience

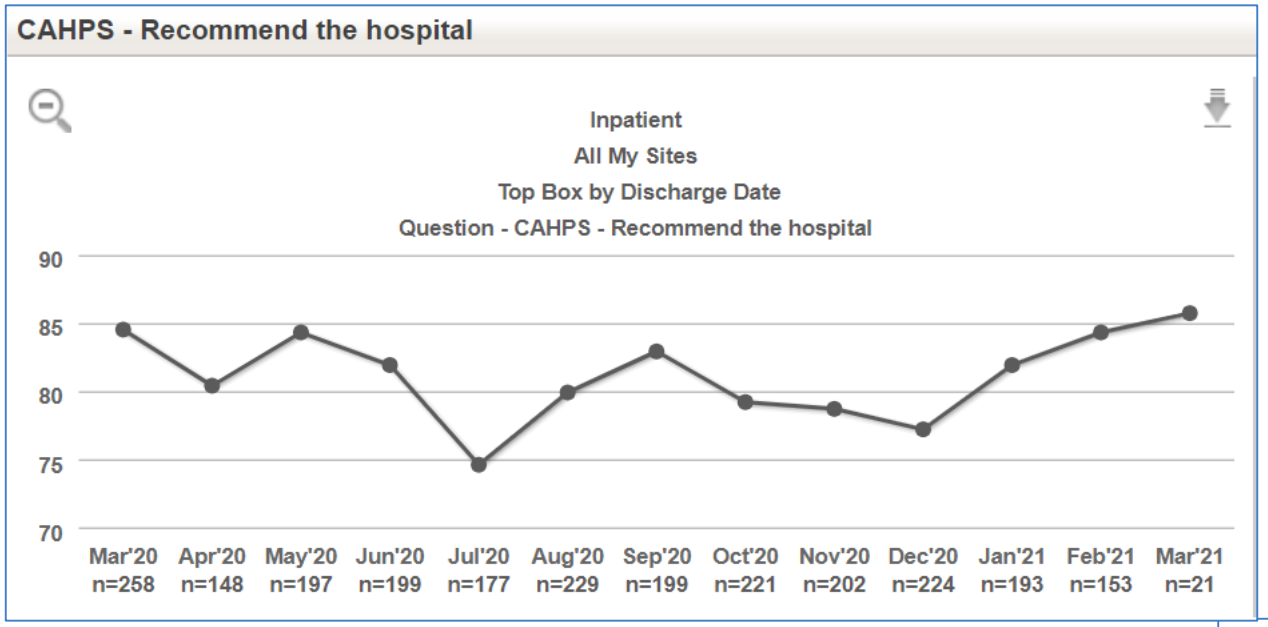
- Each service area has created a plan to improve Likelihood to Recommend performance
  - Utilizing highly correlated patient experience questions (key drivers) to inform their plans

- Restarted and emphasized patient and staff rounding throughout the enterprise
  - Nurse Leader rounding – part of unit plans, with secondary support as needed
  - Leader Rounding – all management involved in rounding on units (patients and staff)
  - Purposeful Hourly Rounding and Bedside Report

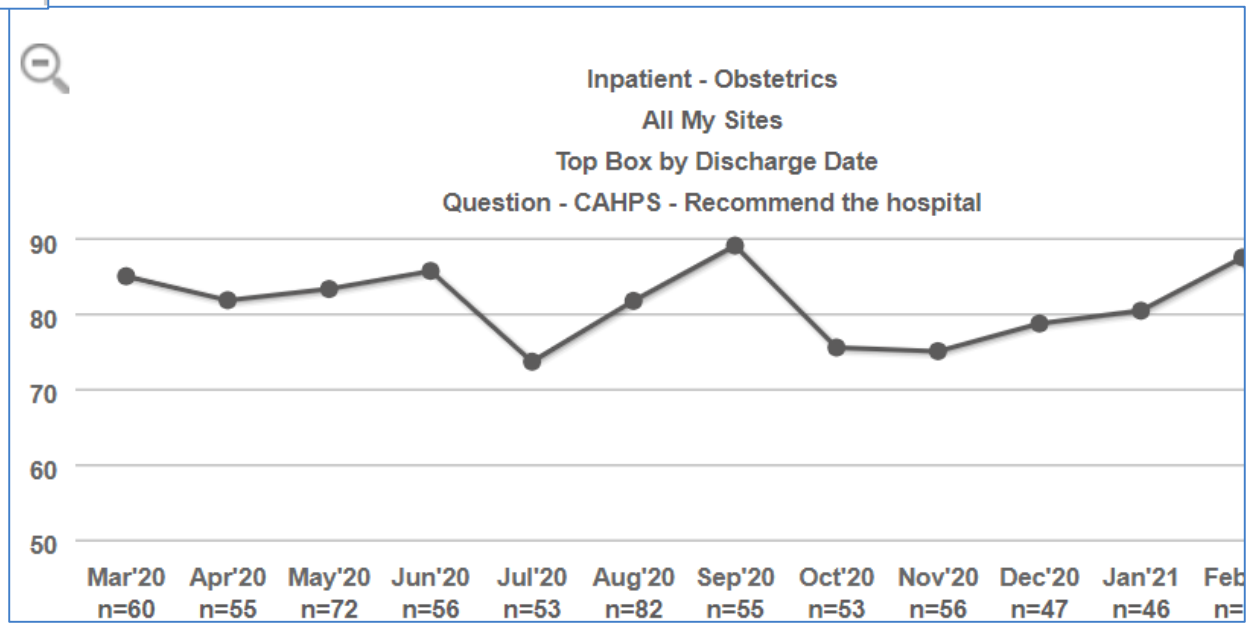
Patient Experience Action Plan Status

Service Area	Current State of LTR	Action Items	Countermeasures
Inpatient Units	• Enterprise -3.5 • MV -5.1 • LG -1.1	Meeting every week Develop plan to achieve 80% target of nurse leader rounding on ALL units Continue to work on 'bundle' (nurse leader rounding, hourly rounding, BSR) Continue to focus on safety / trust (use the words that work) Staff worked together best practices Discharge phone calls coming soon	• Weekly check in with nursing leaders
MBU	• Enterprise -3.6 • MV -4.8 • LG -1.3	Develop plan to achieve 80% target of nurse leader rounding Continue to work on 'bundle' (nurse leader rounding, hourly rounding, BSR) Continue to focus on safety / trust (use the words that work) Staff worked together best practices Discharge phone calls coming soon	• Weekly check in with nursing leaders
ED	• Enterprise -2.0 • MV -0.5 • LG -3.4	Focused Rounding Efforts Communication plan (especially those being admitted) Staff Worked Together Best Practices Facility Improvements	• Weekly Gemba walks
Outpatient Surgery	• Enterprise -1.2 • MV +0.1 • LG -2.6	WeCare behaviors (using the words comfort and communication about delays / wait times) Focus on discharge and recovery (including Emmi patient education) Facility cleanliness	
Outpatient Services (Imaging)	• Enterprise -2.2 • MV -2.3 • LG -2.5	Meeting every two weeks Continue to focus on WeCare behaviors (words that work) around wait times / comfort / staff worked together Develop standard process for keeping patients informed of wait times WeCare training of PSR's Focused rounding on high volume, lower performing areas	
Outpatient Services (Lab)	• Enterprise 0 • MV -0.5 • LG +0.8	WeCare behaviors (using the words comfort and communication about delays / wait times) Regular meeting cadence set up Standard process for keeping patients and families updated on wait times and delays Covid-19 testing move to Melchor 2/8/21 will help with feelings of safety Standard process to inform patients of when and how they'll receive their test results	
Oncology	• Enterprise -2.6	Work on care coordination / sensitivity / privacy Calling patient 24 hours prior to visit to provide expectations for visit and most current Covid protocols Wait time communication plan	
ECHMN (NPS)	• ECHMN +0.2	We-Care Launch (best practices, training, recognition) Feedback module being developed	

Inpatient LTR

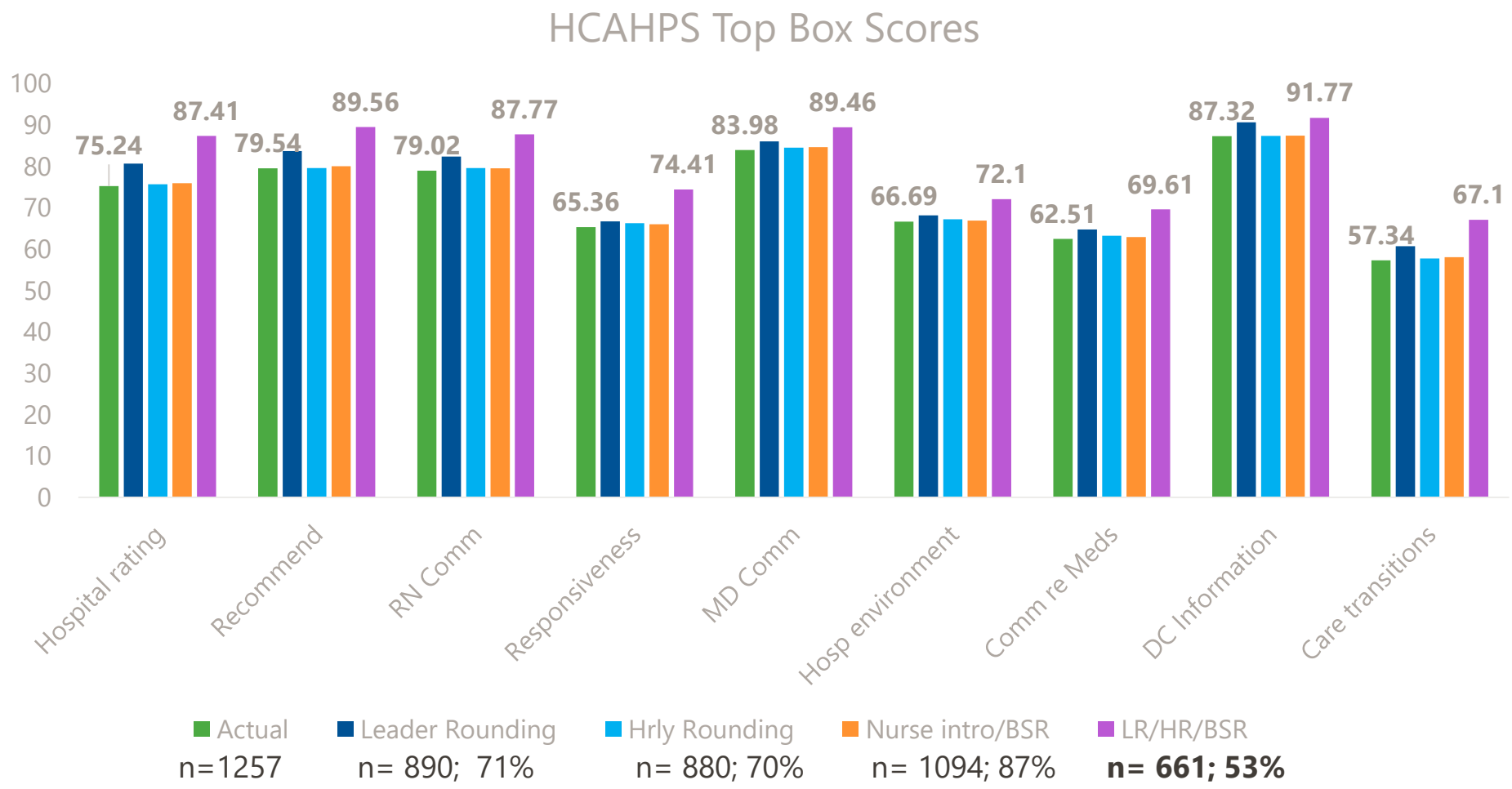


MCH LTR



El Camino Health

Hourly Rounding, Leader Rounding, Bed-Side Shift Bundle

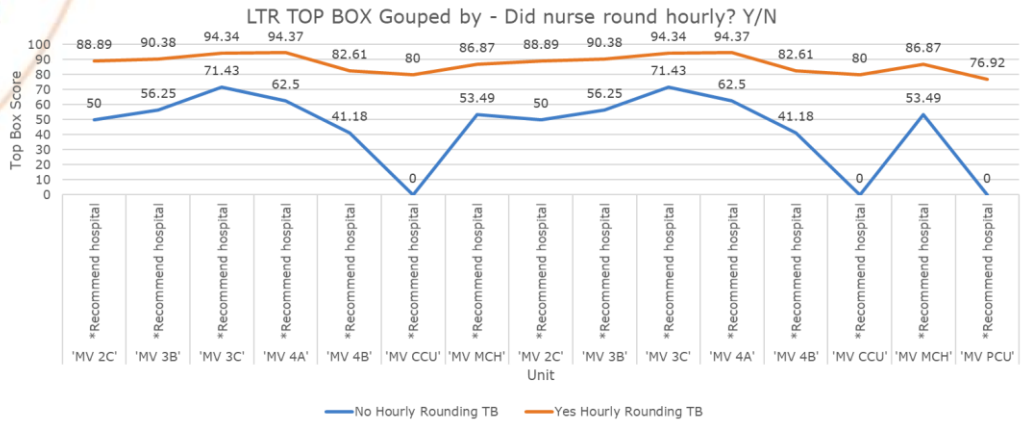


OPPORTUNITY: **53%** of patients reported receiving the full bundle

PRESS GANEY®

Based on surveys received 7/1/20 – 12/31/20

Benefits of Hourly Rounding



Purposeful Rounding

PPEPP Checklist — Middle Hours of Shift

Intro: Our goal is to proactively meet your needs and we do this by coming in and checking on you on a regular basis to make sure you have everything you need. We call this purposeful rounding.

Pain	• **"Let's talk about your pain.** Tell me how you are feeling." • "Can you **describe the pain and rate it** on our scale for me?"
Potty	"While I am here with you for our hourly round, **I would like to assist you to the bathroom**, does that sound like a good idea?"
Environment	"Let's take a second to make sure you have what you need." ✔ **Tissues, call light, phone, water, personal items all in reach** ✔ **No trash on the floor or table**
Positioning	**"Are you comfortable?"** Check for change of position needs, room temp, extra pillows, etc.
Pumps	"Before I leave, **I am going to check your pump**."
Closing	**"What questions do you have for me?"** I will be back to check on you again in about an hour.

El Camino Health

Purposeful Rounding

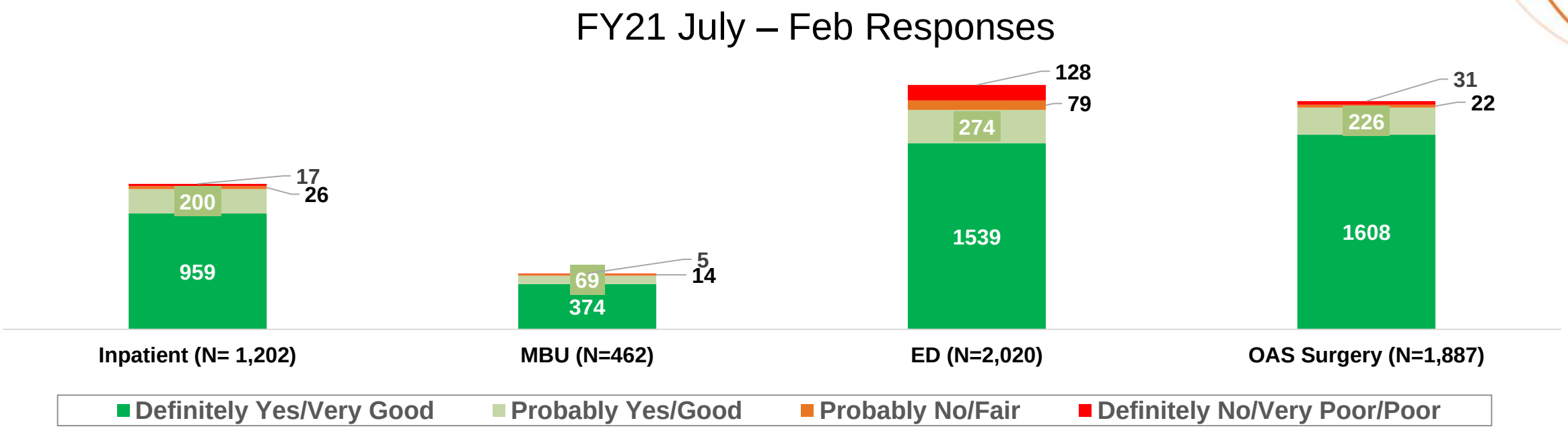
Bedside Hand-off

Preparing for Handoff Outgoing Nurse	Last hour of shift, outgoing staff informs the patient that she/he will be finishing their shift and explains to patient about the bedside hand-off process.
Bedside Hand-off	Outgoing and oncoming nurse enter room together and greet patient at the bedside; perform introductions and manage up the oncoming nurse.
Outgoing and Oncoming Nurses	Incoming nurse updates the whiteboard.
	Using **INTROS**, the outgoing nurse relays all clinical information to oncoming nurse and invites the patient to ask questions or add information.
Closing	• Ask patient, **"What questions do you have?"** • **"I will be back to check on you again in about an hour."**

El Camino Health

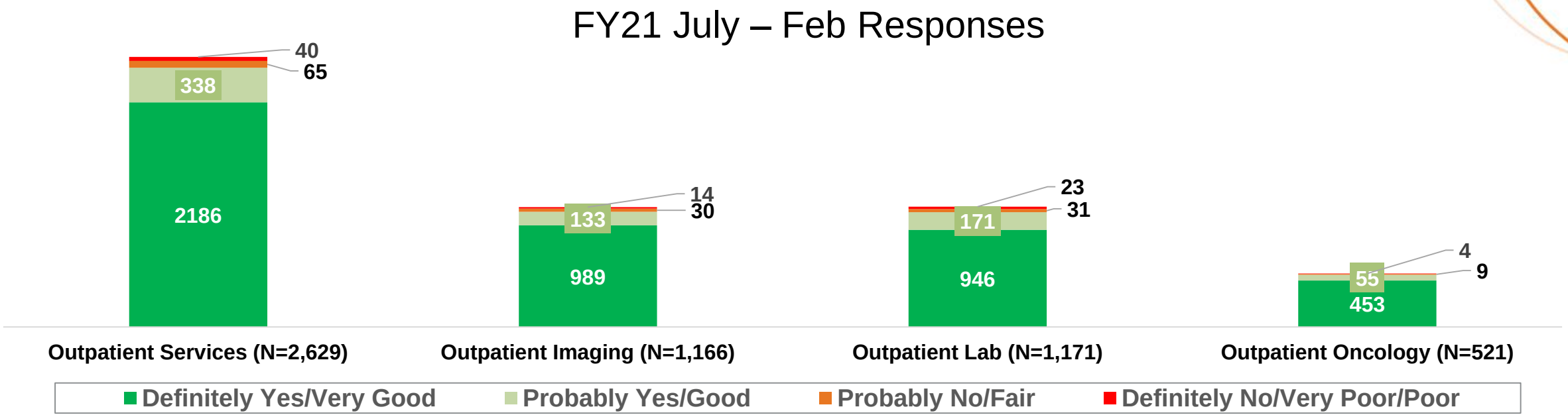
El Camino Health

Enterprise LTR : Gap Analysis



Enterprise	Inpatient Units (CAHPS)	MCH (CAHPS)	ED (Press Ganey)	OAS Surgery (CAHPS)
Top Box Target FY21	83.3%	84.6%	78.2%	86.4%
Top Box FY21 YTD	79.8%	81.0%	76.2%	85.2%
Gap to Top Box Target	(-42) Approx. 5 per month	(-17) Approx. 2 per month	(-41) Approx. 5 per month	(-22) Approx 3 per month
% of Responses that are GOOD / VERY GOOD or DEFINITELY YES / PROBABLY YES	**96.4%**	**95.9%**	**89.8%**	**97.2%**

Enterprise LTR : Gap Analysis



Enterprise	Outpatient Service	Outpatient Imaging	Outpatient Lab	Outpatient Oncology
Top Box Target FY21	86.2%	87.0%	80.8%	89.6%
Top Box FY21 YTD	83.2%	84.8%	80.8%	87.0%
Gap to Top Box Target	(-80) Approx. 10 per month	(-25) Approx. 3 per month	0 - At Target	(-14) Approx. 2 per month
% of Responses that are GOOD / VERY GOOD or DEFINITELY YES / PROBABLY YES	**96.0%**	**96.2%**	**95.4%**	**97.5%**

Always Culture

Always Events are aspects of the experience that are so important to patients that we must perform them consistently….every patient, every time

Questions?

Appendix

Press Ganey Award Winners 2020

PRACTICE	% REPORT IN USE	% REPORT EFFECTIVE
Bedside shift report	76%	99%
Formal patient experience training/education for all staff	86%	99%
Formal service recovery program	88%	98%
Leader rounds on staff	89%	100%
Nurse leader rounds on patients	82%	99%
Post-discharge/post-visit phone calls	94%	99%
Purposeful hourly rounds	79%	99%
SBAR (Situation, Background, Assessment, Recommendation) communication	89%	98%
Share patient experience survey results with physicians	99%	97%
Teach-back	87%	100%
Whiteboards/communication boards	95%	99%

Of special note are four practices from the above list with robust industry research support: bedside shift report, leader rounds on staff, nurse leader rounds on patients, and purposeful hourly rounds. Press Ganey data analyses reveal that organizations that adopt all of these practices as a nursing communication bundle outperform organizations that do none of these practices or that implement only one or two of them.

Key Drivers

Key Drivers

IP-Enterprise	MV	TB Ratio	LG	TB Ratio
	Staff worked together care for you	2.02	Nurses treat with courtesy/respect (CAHPS)	2.33
	Nurses treat with courtesy/respect (CAHPS)	2.12	Staff worked together care for you	2.18
	Friendliness/courtesy of the nurses	1.69	Friendliness/courtesy of the nurses	1.84
MCH - Enterprise	MV	TB Ratio	LG	TB Ratio
	Nurses treated with courtesy/respect (CAHPS)	2.14	Staff worked together care for you	2.34
	Staff worked together care for you	1.95	Staff included you in decisions	2.57
	Friendliness/courteous of the nurses	1.54	Friendliness / courtesy of childbirth unit	1.91
ED - Enterprise	MV	TB Ratio	LG	TB Ratio
	Deg hosp staff worked as a team	3.47	Safe/secure felt in ER/ED	2.63
	Nurses response to questions	4.17	Nurses courtesy	2.58
	Staff cared about you as a person	3.4	Staff cared about you as person	3.01
	Nurses courtesy	3.83	Nurse took time to listen	2.92
	Safe/secure felt in ER/ED	3.13	Nurse attention to your needs	2.82
OAS- Enterprise	MV	TB Ratio	LG	TB Ratio
	Staff treat w/ courtesy, respect (CAHPS)	4.22	Facility clean (CAHPS)	3.71
	Staff ensure you were comfortable (CAHPS)	3.36	Staff treat w/ courtesy, respect (CAHPS)	3.59
	Facility clean	2.79	Staff ensure you were comfortable (CAHPS)	2.2
	Clerks and reception courteous (CAHPS)	2.43	Clerks and receptionists helpful (CAHPS)	1.76
OP Services - Enterprise	MV	TB Ratio	LG	TB Ratio
	Staff worked together care for you	4.27	Staff worked together care for you	4.4
	Treated you with respect/dignity	4.43	Treated you with respect/dignity	5.11
	Response to concerns/complaints	3.35	Friendliness of physician	2.54
	Degree of safety and security felt	3.31	Explanations given by physician	2.75
OP Oncology	MV	TB Ratio	LG	TB Ratio
	Safety and security felt in center	1.98		
	Facility cleanliness	1.91		
	Care coordinated among Drs/caregvrs	1.95		
	Concern for privacy	1.81		

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: April 5, 2021
Subject: Board Quality and Safety Dashboard

Purpose: Review analysis of COVID-19 impact on mortality and readmission index

Summary:

1. Situation: At a previous Board QC meeting, the potential impact of the COVID-19 surge of admissions on readmission and mortality index was discussed.

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

3. Background: There has been speculation that the surge in hospitalized COVID-19 patients over the past several months has contributed to the observed increase in both readmission and mortality indices. For mortality index, a hypothesis was proposed that the Risk of Morality (ROM) and Severity of Illness (SOI) scores may be lower than what might be expected which would drive down the "expected" mortality used in calculating the mortality index (O/E). Regarding readmissions, it has been noted nationally that COVID-19 patients are more prone to being readmitted.

4. Assessment: Based on the 12 month data included in the attachment it does appear that the COVID-19 inpatients cared for at El Camino Health did have a higher than expected readmission rate which was 1.27, considerably higher than the whole population rate which was less than 1.0. Similarly, the COVID-19 mortality index for inpatients was higher at 0.90, also higher than the whole population. The COVID-19 effect is higher for readmission than for mortality however indicating that there may be additional factors at work to account for the higher whole population mortality index.

5. Other Reviews: None

6. Outcomes: This provides more insight into the recently experienced increase in mortality and readmission index.

List of Attachments: COVID-19 mortality and readmission data summary

Suggested Committee Discussion Questions: None.

COVID - 30 day Readmission Report: 1/1/2020 - 12/31/2020

Prompt Details: Facility:El Camino Hospital Los Gatos (661972) (CA) (Facility:07-01-2015 to 02-18-2021) (Peer:07-01-2015 to 10-31-2020), El Camino Hospital Mountain View (635796) (CA) (Facility:07-01-2015 to 02-17-2021) (Peer:07-01-2015 to 10-31-2020)
{Discharge Date} Between 1/1/2020 and 12/31/2020
Inpatient/Outpatient: Inpatient
Readmit Ver Ind All-Cause Hospital-Wide 30-Day Readmission Methodology with Planned Readmission Algorithm v4.0 (discharges 10/01/2015 and forward)
({Secondary Diagnosis - 7 Digit (ICD-10)}:
U07.1:COVID-19, B97.29:OTH CORONAVIRUS CAUSE DZ ELSEWHERE)
Or
({Principal Diagnosis - 7 Digit (ICD-10)}:
B97.29:OTH CORONAVIRUS CAUSE DZ ELSEWHERE, U07.1:COVID-19)
{Patient Type}:
INPATIENT

Source	Criteria	Run Date	Month/ Year	Total Cases	Outcome Cases	Outcome Cases with Readmissions	Observed	Expected	Variation	O/E	SS	Comments
			Total	**435**	**378**	**35**	**9.26%**	**7.30%**	**1.96%**	**1.27**	'--	
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	JAN 2020	17	17	2	11.76%	15.30%	-3.53%	0.77		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	FEB 2020	12	9	0	0.00%	17.10%	-17.10%	0.00		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	MAR 2020	23	16	1	6.25%	6.94%	-0.69%	0.90		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	APR 2020	23	20	4	20.00%	6.61%	13.39%	3.03		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	MAY 2020	7	5	0	0.00%	5.36%	-5.36%	0.00		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	JUN 2020	12	12	0	0.00%	6.13%	-6.13%	0.00		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	JUL 2020	25	22	0	0.00%	4.94%	-4.94%	0.00		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	AUG 2020	49	41	1	2.44%	6.44%	-4.00%	0.38	*	
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	SEP 2020	29	27	6	22.22%	6.70%	15.52%	3.32	*	
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	OCT 2020	24	23	1	4.35%	8.24%	-3.89%	0.53		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	NOV 2020	36	33	3	9.09%	5.30%	3.79%	1.71		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	DEC 2020	176	152	17	11.18%	7.07%	4.11%	1.58	*	January 2021: There were (2) Covid-19 Rehabilitation patients. Readmission logic considers only patients assigned an Inpatient patient type (thus ignores both Psychiatric & Rehabilitation patient types).

COVID - Mortality Report 1/1/2020 to 1/31/2021

Risk Calc Mode: Standard

Prompt Details:
Facility:El Camino Hospital Mountain View (635796) (CA) (Facility:07-01-2015 to 02-17-2021) (Peer:07-01-2015 to 10-31-2020), El Camino Hospital Los Gatos (661972) (CA) (Facility:07-01-2015 to 02-18-2021) (Peer:07-01-2015 to 10-31-2020)
{Discharge Date} Between 1/1/2020 and 1/31/2021
Inpatient/Outpatient:Inpatient
({Secondary Diagnosis - 7 Digit (ICD-10)}:
U07.1:COVID-19, B97.29:OTH CORONAVIRUS CAUSE DZ ELSEWHERE)
Or
({Principal Diagnosis - 7 Digit (ICD-10)}:
B97.29:OTH CORONAVIRUS CAUSE DZ ELSEWHERE, U07.1:COVID-19)

Source	Criteria	Run Date	Month / Year	Total Cases	Outcome Cases	Total Deaths	Observed	Expected	Variation	O/E	SS	Opportunity (Mortality)
			Total	**642**	**634**	**74**	**11.67%**	**12.96%**	**-1.29%**	**0.90**	'--	
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	JAN 2020	17	17	0	0.00%	4.99%	-4.99%	0.00		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	FEB 2020	13	13	3	23.08%	10.55%	12.52%	2.19		1
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	MAR 2020	23	21	5	23.81%	17.80%	6.01%	1.34		1
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	APR 2020	24	24	3	12.50%	16.21%	-3.71%	0.77		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	MAY 2020	7	7	1	14.29%	18.34%	-4.06%	0.78		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	JUN 2020	12	12	0	0.00%	5.26%	-5.26%	0.00		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	JUL 2020	25	25	2	8.00%	6.95%	1.05%	1.15		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	AUG 2020	49	47	2	4.26%	7.76%	-3.51%	0.55	*	
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	SEP 2020	29	28	1	3.57%	8.25%	-4.68%	0.43	*	
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	OCT 2020	24	24	1	4.17%	8.21%	-4.04%	0.51		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	NOV 2020	36	35	2	5.71%	7.25%	-1.53%	0.79		
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	DEC 2020	176	176	22	12.50%	15.44%	-2.94%	0.81	*	
Premier QA	Premier Focus Population - Coronavirus - Inpatient	3/5/2021	JAN 2021	207	205	32	15.61%	15.15%	0.46%	1.03		1

Disclosure: Data may not be finalized and all patients may not be included for (NOV20, DEC20, JAN21, FEB21)

El Camino Health

Quality Committee Meetings
Proposed FY22 Dates

RECOMMENDED QC DATE MONDAYS	CORRESPONDING HOSPITAL BOARD DATE
Monday, August 2, 2021	Wednesday, August 18, 2021
Tuesday, September 7, 2021	Wednesday, September 8, 2021
Monday, October 4, 2021	Wednesday, October 13, 2021
Monday, November 1, 2021	Wednesday, November 10, 2021
Monday, December 6, 2021	Wednesday, December 8, 2021
Monday, February 7, 2022	Wednesday, February 9, 2022
Monday, March 7, 2022	Wednesday, March 9, 2022
Monday, April 4, 2022	Wednesday, April 13, 2022
Monday, May 2, 2022	Wednesday, May 11, 2022
Monday, June 6, 2022	Wednesday, June 8, 2022

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: April 5, 2021
Subject: Board Quality and Safety Dashboard

Purpose: Review proposed strategic goals for FY22

Summary:

1. Situation: The El Camino Health Strategic Goals for FY22 are now being developed by management. Since the Board QC will be asked to recommend approval of the final proposed strategic goals pertaining to quality, safety and patient experience, this is an opportunity to introduce to the committee the initial draft of those goals.

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: The proposed strategic goals for FY22 are ready for a "first pass" with the QC. The strategic goals are the key focused goals that are intended to drive the entire organization toward a common endpoint which aligns with the overall vision for El Camino Health. The guiding principles for strategic goal selection are as follows:

A. Significantly impacts quality, safety, and experience

B. Easy to understand and communicate

C. Broad reach across the entire enterprise

D. Impacts financial performance

E. Impacts consumer choice

F. Aligns with the strategic plan

The actual metrics will be determined once the final data is available for FY21 which will not be complete until September or October of FY22. However, the methodology for setting the metrics will be determined prior to the end of FY21. Many of the quality and safety goals are multi-year endeavors but metrics will be applied on an annual basis. If a multi-year goal is achieved sooner than expected—for example mortality index—then that goal will be dropped from the strategic goal category. A goal that is "dropped" is not ignored but is moved into a less prominent position. (We track hundreds of quality and safety metrics on an ongoing basis.)

4. Assessment: Based on the principles cited above we are proposing the following strategic goals for FY22:

A. **Serious Safety Event Rate (SSER):** This is a measure of high reliability (HRO) and continues from FY21. This aligns with our true north quality pillar of zero preventable harm.

B. **Readmission Index:** This reflects our ability to provide a continuity of care; can be influenced by many parts of the organization including ambulatory (SVMD); affects our Medicare Readmission Penalty Program score; affects our CMS Bundled Payment for Clinical Improvement-Advanced success.

C. **HEDIS Composite:** This is a key indicator of quality in the ambulatory space and the components also contribute to payer ratings and MIPS scores.

D. **Culture of Safety (employees):** This is foundational to the HRO journey success to be able to hardwire the zero harm mindset.

E. **Culture of Safety (physicians):** Same as above. Physicians and other clinicians must be of similar minds on this.

5. Other Reviews: None

6. Outcomes: The Quality Committee will provide feedback to this draft. (The organizational incentive goals will be chosen from these strategic goals at a later date.)

List of Attachments:

1. Power Point showing a comparison between FY21 and proposed FY22 goals.

Suggested Committee Discussion Questions:

1. Does this make sense and is it consistent with our overall quality strategy?

Proposed DRAFT FY22 Goals

FY21 Strategic / Org Goal	FY22 Strategic / Org Goal
QUALITY	
SSE Rate	**SSE Rate**
Readmission Index	**Readmission Index**
HEDIS Composite Score	**HEDIS Composite Score**
Risk Adjusted Mortality	**Culture of Safety (employee)**
Patient Throughput	**Culture of Safety (physician)**
SERVICE	
Likelihood to Recommend (LTR)	**Likelihood to Recommend (LTR)**
PEOPLE	
Employee Engagement	**Employee Engagement**
MD Alignment	**MD Alignment**
FINANCE	
Operating EBIDA	**Operating EBIDA**
Operating Expense per CMI Adjusted Discharge	**Operating Expense per CMI Adjusted Discharge**
GROWTH	
Adjusted Discharges	**Adjusted Discharges**
Unique Ambulatory Lives	**Unique Ambulatory Lives**
Total Ambulatory Visits	**Patient Throughput**

El Camino Health

FY22 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	- FY21 Achievement and Metrics for FY22 (Q1 FY22) - FY23 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; include OPPE and FPPE education	Q2, Q3	- Receive update on implementation of peer review process changes (FY22) - Receive update on OPPE and FPPE (FY22)
3. Review Quality, Patient Care and Patient Experience reports and dashboards	- FY22 Quality Dashboard (Q1-Q2 review; monthly consent for review and discussion, if needed) - CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS), - Leapfrog, CMS Star, Readmission Penalty, HAC penalty, VBP results annually	Review reports per Pacing Plan timeline –
4. Review Board Dashboard using STEEEP Methodology and propose changes as appropriate	Semi – Annually Q2 and Q4	Review Dashboard and Recommend Changes to the Board
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

Pending approval by the Board June 2021

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: April 5, 2021
Subject: Value Based Purchasing (VBP) estimated impact for Federal Fiscal Year 2022

Recommendation(s): Review report noting measure results that are below benchmark in red. Note that this is the first VBP report in which ECH has a positive net impact in that ECH will receive an additional $375,012 in DRG payments over FFY22, above the 2% withhold.

Summary: Provide the Committee with a preview of estimated impact of VBP measures on ECH DRG payments effective October 1, 2021 (FFY 2022)

1. Authority: The Quality Committee of the Board is responsible for the quality and safety of care provided to ECH patients.

2. Background: Value Based Purchasing is CMS' effort at Pay for Performance. In its 8th year, VBP adjusts Medicare inpatient reimbursement based on hospital's performance on quality, safety, and patient experience measures. Medicare withholds 2% of a hospital's anticipated DRG payments. Hospitals can earn back all of the 2% and more if it performs well, or lose some if it does not.

3. Assessment:

- Estimated net impact of VBP for FFY 2022 is $375,012, a bonus amount of +1.845% above the 2% DRG payment withhold. This is compared to a loss of ($195,983)) for FFY2021.
- Medicare Spending per Beneficiary score stayed the same as FY 2021), earning a 1 point improvement score and allowing a domain score of 10.
- For each of the five mortality rates in the Clinical Outcomes Domain and the one complication rate for THA/TKA El Camino exceeded the thresholds and earned performance points.
- In the Safety Domain, ECH exceeded the threshold and earned performance points for all measures, except Hospital-acquired Lab ID Methicillin-resistant Staphyloccoccus aureas and abdominal hysterectomy SSI.
- Organization goal focus continues on HCAHPS measures in Person/Community Engagement with thresholds exceeded and performance points earned for all but Responsiveness of Hospital staff, and Discharge Information.

4. Other Reviews: N/A

5. Outcomes: N/A

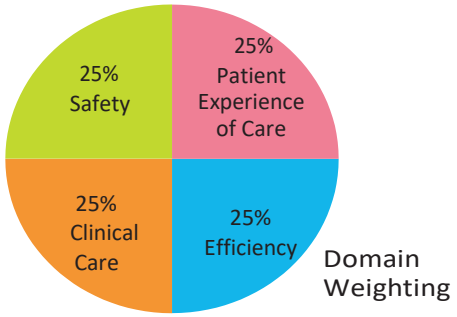
Suggested Committee Discussion Questions: None.

List of Attachments: ECH Value-Based Purchasing estimate for FFY 2022

Hospital Value-Based Purchasing: El Camino Hospital

FFY 2022 (effective 10/1/2021)

Base Operating DRG Payments	Withhold Amount/ % of revenue -2.00%	Bonus Amount	Net Impact / 0.36%	Estimated Total Score
$102,827,559	$2,056,551	$ 2,431,563	$ 375,012	33.9 %



Safety (25% of Total Performance Score) Domain Score = 40

Baseline period		Performance period	
HAI: CY 2018		HAI: CY 2020	
Description	**Threshold**	**Performance/ Points**	**Benchmark**
Catheter-Associated Urinary Tract Infection	0.633	0.69/5	0.000
Central Line-Associated Blood Stream Infection	0.727	0.28/6	0.000
Clostridium difficile Infection	0.646	0.43/4	0.047
Methicillin-Resistant *Staphylococcus aureus* Bacteremia : HO LabID	0.748	1.33/0	0.000
Surgical Site Infection: Colon Surgery (HAI 3) Abdominal Hysterectomy (HAI 4)	 0.749 0.727	 0.177/7 1.062/0	 0.000 0.000
Surgical Site Infection Composite	N/A	N/A	N/A

Infections are SIRs. Lower is better for all measures.
**Threshold values will be modified when re-baseline data is released.*

Person/Community Engagement (25% of Total Score) Domain Score = 34

Baseline period		Performance period	
CY 2018		CY 2020	
Description	**Performance (%)/ Points**	**Threshold (%)**	**Benchmark (%)**
Communication with Nurses	80%/1	79.18	87.53
Communication with Doctors	82%/3	79.72	87.85
Responsiveness of Hospital Staff	65%/0	65.95	81.29
Communication about Medicines	66%/3	63.59	74.31
Hospital Cleanliness and Quietness	67.5%/2	65.46	79.41
Discharge Information	86%/0	87.12	91.95
Care Transitions	54%/2	51.69	63.11
Overall Rating of Hospital	79%/5	71.37	85.18

Higher is better for all scores.

Clinical Outcomes (25% of Total Performance Score) Domain Score = 63.33

Baseline period			Performance period	
Mort - 7/2012-6/2015			9/1/2017-6/30/2020	
THA/TKA Complications – 4/1/2012–3/31/2015			4/1/2017–3/3/2020	
Measure ID	**Description - Mortality Rate**	**Threshold %**	**Performance /Points**	**Benchmark %**
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-day mortality rate	0.14	0.11/10	0.12
MORT-30-HF	Heart Failure (HF) 30-day mortality rate	0.12	0.10/10	0.10
MORT-30-PN	Pneumonia (PN) 30-day mortality rate	0.16	0.13/1	0.13
MORT-30-COPD	COPD 30-day mortality rate	0.08	0.07/4	0.06
THA/TKA	Primary THA/TKA complication rate	0.03	0.03/6	0.02
MORT-30-CABG	CABG 30-day mortality rate	0.03	0.03/7	0.02

Efficiency (25% of Total Performance Score) Domain Score = 10.0

Baseline period			Performance period	
CY 2018			CY 2020	
Measure ID	**Description**	**Threshold**	**Performance /Points**	**Benchmark**
MSPB-1	Medicare Spending per Beneficiary	Median MSPB ratio hospitals during performance period 0.99	0.99/1	Mean of the lowest decile MSPB ratios for all hospitals during performance period – 0.85

Lower is better for all scores.

Adapted by Qualis Health from materials provided by Stratis Health and prepared under contract with the Centers for Medicare & Medicaid Services (CMS), and agency of the U.S. Department of Health and Human Services.