El Camino Health

AGENDA

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

Monday, May 3, 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 – 5:43**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (04/05/2021) ***Information*** b. Progress Against FY21 Committee Goals c. FY21 Enterprise Quality Dashboard d. Report on Board Actions e. Quality Committee Follow-Up Tracking f. Pacing Plan g. Article of Interest			
4.	**CHAIR'S REPORT**	Julie Kliger, Quality Committee Chair		**information 5:43 – 5:46**
5.	**PATIENT STORY** **ATTACHMENT 5**	Cheryl Reinking, RN, CNO		**discussion 5:46 – 5:51**
6.	**PROPOSED FY22 STRATEGIC GOALS** **ATTACHMENT 6**	Mark Adams, MD, CMO	*public comment*	**possible motion 5:51 – 6:11**
7.	**PROPOSED FY22 PACING PLAN** **ATTACHMENT 7**	Mark Adams, MD, CMO	*public comment*	**possible motion 6:11 – 6:16**
8.	**EL CAMINO HEALTH MEDICAL NETWORK REPORT** **ATTACHMENT 8**	Vince Manoogan, Interim President, SVMD		**discussion 6:16 – 6:36**
9.	**QUARTERLY BOARD QUALITY DASHBOARD REPORT** **ATTACHMENT 9**	Mark Adams, MD, CMO		**discussion 6:36 – 6:46**
10.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information 6:46 – 6:49**

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
11.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 6:49 – 6:50**
12.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 6:50 – 6:51**
13.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair		**motion required 6:51 – 6:52**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (04/05/2021) ***Information*** b. Quality Council Minutes			
14.	*Health and Safety Code Section 32155* **Q3 FY21 QUALITY AND SAFETY REVIEW**	Mark Adams, MD, CMO		**motion required 6:52 – 7:07**
15.	*Health and Safety Code Section 32155* **MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, CMO		**motion required 7:07 – 7:17**
16.	*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 7:17 – 7:22**
17.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:22 – 7:23**
18.	**RECONVENE OPEN SESSION/ REPORT OUT**	Julie Kliger, Quality Committee Chair		**information 7:23 – 7:24**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
19.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 7:24 – 7:29**
20.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:29 – 7:30**

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, April 5, 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. Dr. Marfatia 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 Agenda 3c for discussion. Ms. Reinking explained that there were many transfers from LG to MV making it difficult to provide accurate time measurement comparisons so those will be excluded. Jack Po, MD, PhD requested additional context for some of the dashboard metrics. Dr. Adams stated that the annotations accompanying the dashboard have this information but may be hard to read so this can be added to the cover memo. Chair Kliger requested further conversations regarding the OB section. She requested to have a discussion on this topic in the future as she was not clear what was in control and what was not in control. She requested that the assessment section be given more information to know where management was still exploring root cause or not, particularly in the area surrounding OBGYN. **Motion:** To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (03/01/2021); 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:** Ting **Second:** Po **Ayes:** Burn, Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, & Ting **Noes:** None **Abstentions:** None	***Consent Calendar approved***

	Absent: None **Recused:** None	
4. CHAIR'S REPORT	Chair Kliger did not report on the Chair's Report beyond what was presented in the materials.	
5. PATIENT STORY	Cheryl Reinking, RN, CNO, presented a Patient Story. Ms. Reinking stated that the patient should have gone through the drive through for a pre-procedure test and the patient felt they were not provided adequate instructions. Alison Falwell commented that her in-laws found the signage was very helpful in knowing where to go. She said it would be great to have patients join us for this part of the meeting so that we have a richer discussion and learning experience for their story. George Ting, MD stated that while that would be a great idea, he does not believe that would be a good use of the committee's time. Chair Kliger suggested to have a discussion surrounding best practices on how the committee could optimize the voice of the patients.	
6. PATIENT EXPERIENCE (HCAHPS)	Cheryl Reinking, RN, CNO, presented Patient Experience as provided in the packet. She stated that some best practices have not been performed due to COVID restrictions. She stated that each unit looks at their Likelihood To Recommend (LTR) and has particular drivers (i.e. teamwork, communication, etc.). Ms. Reinking stated that the top box scores were lagging and were not being able to be seen on the website. According to Press Ganey, from a percentile ranking, ECH was ranking around the 80th percentile. In response to a committee member's questions, Ms. Reinking stated that the purpose of rounding was to anticipate patient needs proactively. Dr. Ting emphasized the importance regarding the metric of responsiveness.	
7. COVID IMPACT ON MORTALITY AND READMISSION	Mark Adams, MD, CMO, presented the COVID Impact on Mortality and Readmission as presented in the packet. He stated that while it's a big driver, it's not the whole story. He pointed to the sepsis mortality index which he believed was also a driver regardless of COVID. 54% mortality was due to sepsis and 38% of sepsis patients died within two days, which confirms that patients are coming in at a much later stage of sepsis.	
8. PROPOSED FY22 MEETING DATES	Dr. Adams presented the FY22 Meeting Dates and all committee members are in consensus with the meeting dates. There was no motion made.	
9. PROPOSED FY22 STRATEGIC GOALS	Dr. Adams presented the FY22 Strategic Goals provided in the packet. He stated that some items were removed under Quality, but it didn't mean that management had stopped tracking it. Under Quality, the goals included: SSER, readmission index, and HEDIS composite score. Dr. Ting again emphasized the importance of staff responsiveness. Chair Kliger expressed concerns with taking mortality off for inpatient. Dr. Adams commented that mortality will still be monitored and be on the dashboard. The dashboard is socialized throughout the organization. He also stated that the culture of safety survey results would still be brought to the committee. Dan Woods, CEO, stated that mortality should be monitored and also wanted to get a policy started for culture of safety.	
10. APPROVE FY22 COMMITTEE GOALS	Dr. Adams presented the FY21 Committee Goals. He stated the minor adjustments included adding the OPPE.	

	Motion: To approve the FY22 Committee Goals. **Movant:** Sharma **Second:** Burn **Ayes:** Burn, Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, & Ting **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	
11. VALUE BASED PURCHASING REPORT	Dr. Adams presented the Value Based Purchasing Report (VBP). He explained that this was a penalty program where CMS (on paper) adjusts payment starting with a 2% penalty which can be "earned" back plus a potential bonus. It is a zero-sum budget program where multiple hospitals compete with each other to get money. The final results showed ECH on the positive side.	
12. PUBLIC COMMUNICATION	There was no public communication. Dr. Kan announced that the nurses were recognized for exceeding all four indicators on the Nurse Sensitive Indicators.	
13. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:16pm. **Movant:** Burn **Second:** Falwell **Ayes:** Burn, Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Adjourned to closed session at 7:16pm***
14. AGENDA ITEM 19: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:29pm. Agenda items 14-18 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (03/01/2021), Quality Council Minutes, and Medical Staff Credentialing and Privileges Report.	
15. AGENDA ITEM 20: CLOSING WRAP UP	None.	
16. AGENDA ITEM 21: ADJOURNMENT	**Motion:** To adjourn at 7:31pm. **Movant:** Ting **Second:** Burn **Ayes:** Burn, Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Meeting adjourned at 7:31pm***

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

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: May 3, 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.** This month's readmission index dropped down to 1.0 with a reduction in total readmissions to 98 compared to 115 in December and 118 in January. Sepsis was the most frequent diagnostic reason for readmission accounting for 12.
- **B.** Eight SSEs assigned by team review for January: 2 SSIs, 4 HAPIs, 1 reassessment issue and 1 procedure concern in an infant.
- **C.** Mortality Index decreased to 0.98; sepsis continues to be a significant factor
- **D.** HCAHPS Likelihood to Recommend is impacted by continued visitor limitations. Mitigation includes increased emphasis on the "power of 3" which includes nurse leader rounding, hourly nurse rounding, and bedside shift change report.
- **E.** Only 1 C.Diff HAIs for March, moving metric below target.
- **F.** Only 1 Surgical Site Infection in March.
- **G.** Sepsis mortality Index also dropped in March but remains above target.
- **H.** PC-01 at zero, sustained now for 3 months.
- **I.** PC-02, Cesarean Birth above target, OB Task force trending providers and reviewing cases. Will now post unblended data in L&D.
- **J.** Patient Throughput was down for the first time in months with strategies to move patients out of ED. The patient throughput value stream team continues to work on stabilizing the electronic SBAR handoff, improving the Capacity Management Center, and adjusting nurse staffing.

5. Other Reviews: None

6. Outcomes: N/A

Suggested Committee Discussion Questions: None

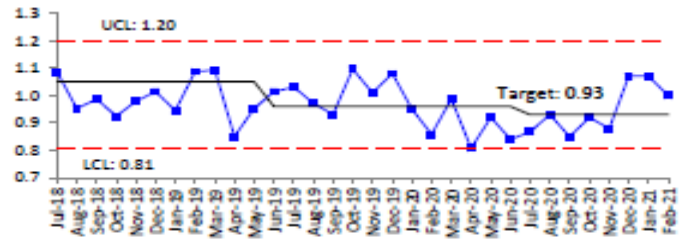
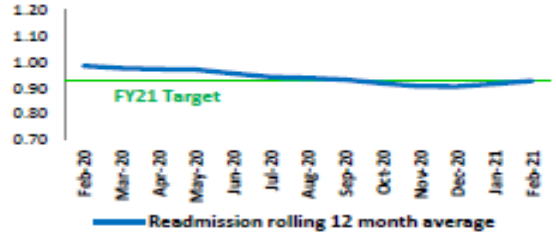
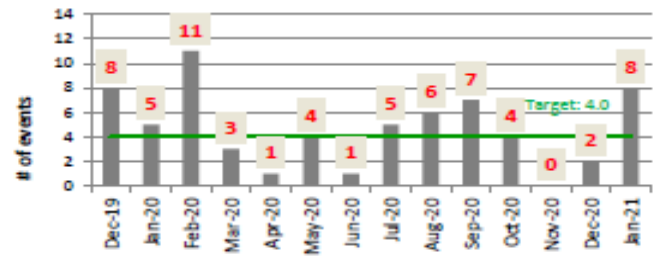
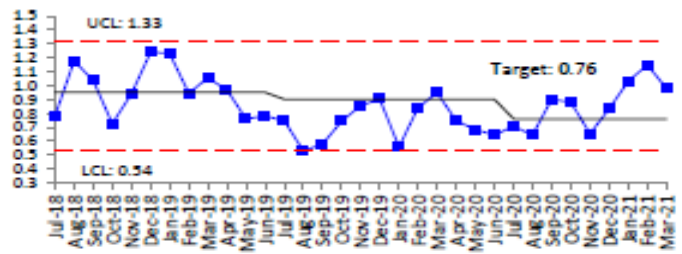
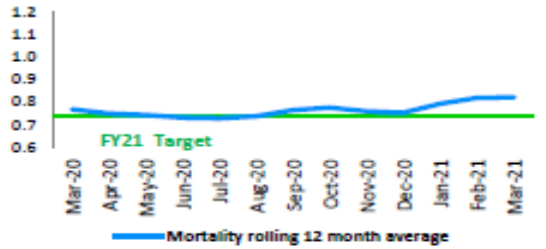
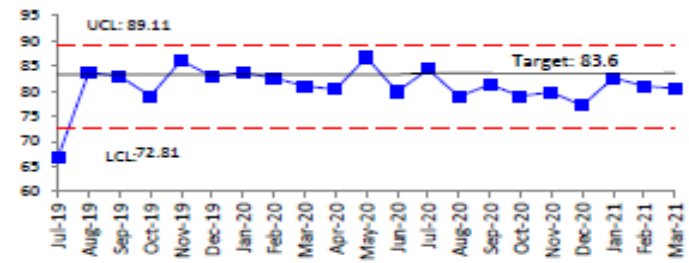
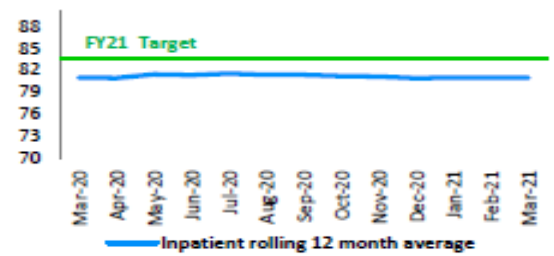
List of Attachments: May 2021 Enterprise Quality, Safety, and Experience Dashboard, March data unless otherwise specified - final results

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

March 2021 (unless otherwise specified)

Month to Board Quality Committee: May, 2021

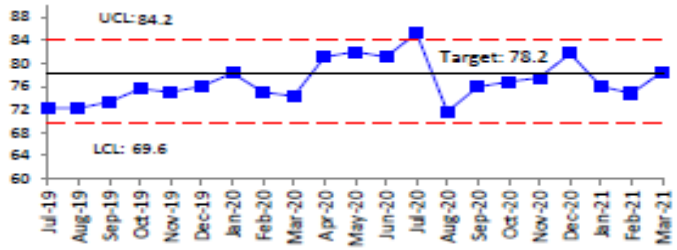
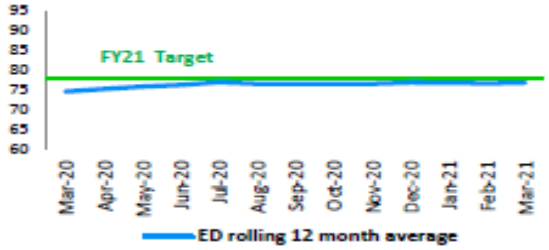
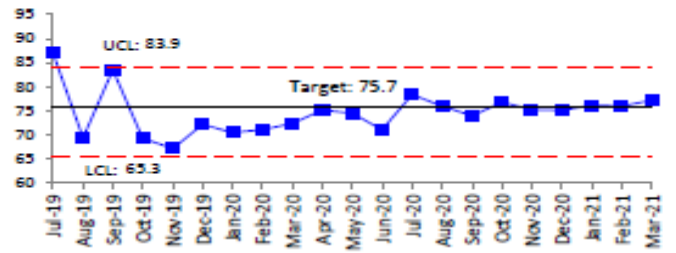
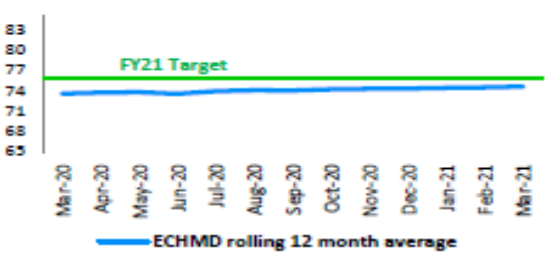
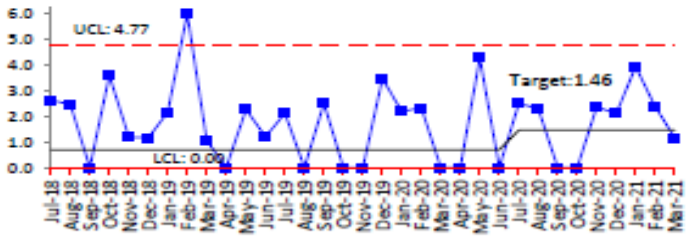
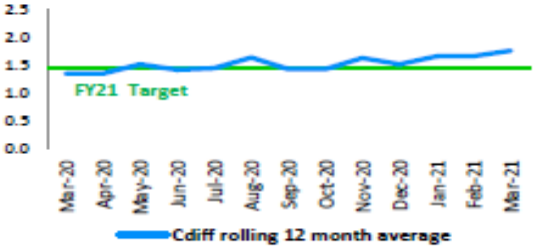
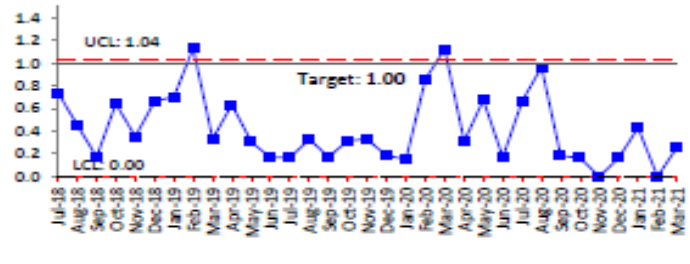
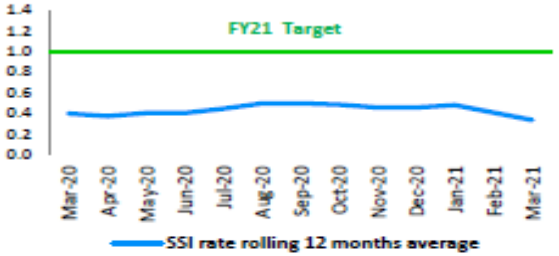
		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of available data)	Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** ***Latest data month: February 2021	1.00 (8.29%/8.27%)	0.95 (7.83%/8.23%)	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: January 2021	8	3.54 (65/183795)	4.28	4.0		
3	* Strategic Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: March 2021*	0.98 (2.18%/2.24%)	0.87 (2.04%/2.33%)	0.74	0.76		
4	*Organizational Goal **IP Enterprise - HCAHPS Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: March 2021*	80.5	80.2	83.1	83.6		

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

March 2021 (unless otherwise specified)

Month to Board Quality Committee: May, 2021

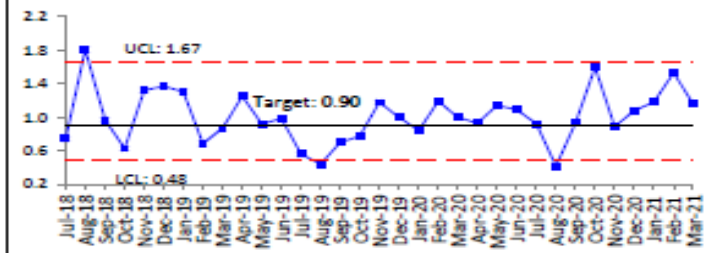
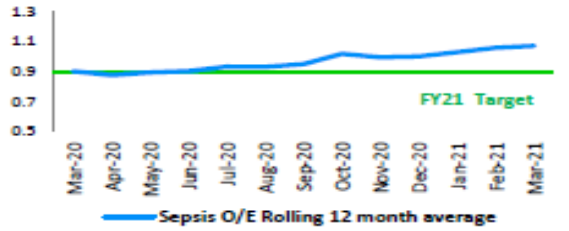
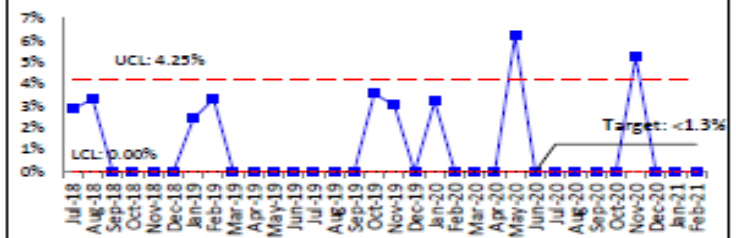
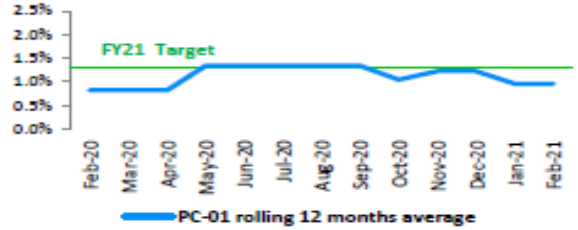
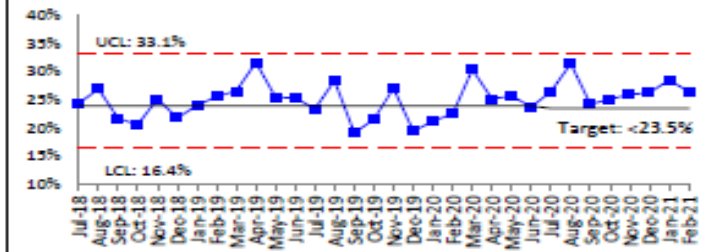
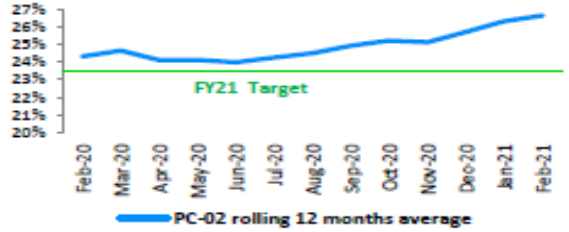
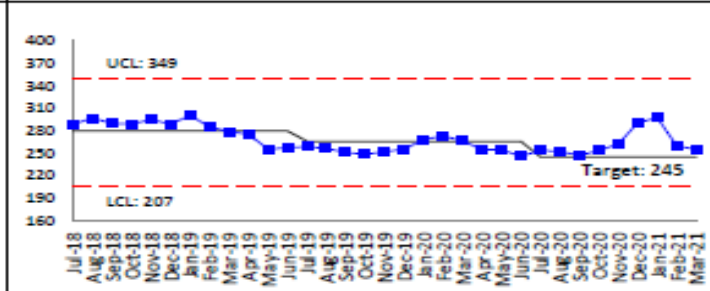
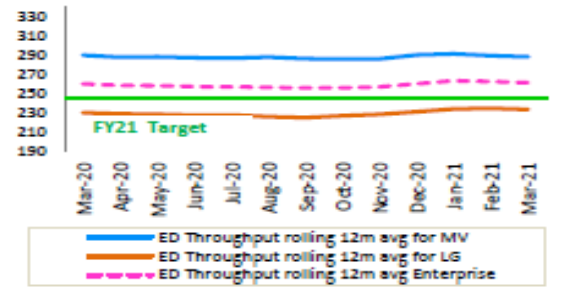
		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of available data)	Rolling 12 Month Average
		Latest month	FYTD				
5	* Organizational Goal ED Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted *Latest data month: March 2021*	78.5	76.5	75.7	78.2		
6	* Organizational Goal ECH MD : Likelihood to Recommend Care Provider (SVMD only) Top Box Rating of 'Always' %, Unadjusted *Latest data month: March 2021*	77.1	76.1	73.2	75.7		
7	*Hospital Acquired Infections* *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Latest data month: March 2021*	1.17 (1/8549)	1.88 (15/79922)	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: March 2021*	0.26 (1/392)	0.33 (16/4902)	0.36	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

March 2021 (unless otherwise specified)

Month to Board Quality Committee:
May, 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: March 2021*	1.16 (14.77%/12.77%)	1.08 (13.53%/12.54%)	0.98	0.90		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) **Latest data month: February 2021*	MV: 0.0% (0/22) LG: 0.0% (0/1) ENT: 0.0% (0/23)	MV: 0.6% (1/170) LG: 0.0% (0/45) ENT: 0.47% (1/215)	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: February 2021*	MV: 30.0% (33/110) LG: 11.5% (3/26) **ENT: 26.5%** (36/136)	MV: 27.9% (290/1038) LG: 22.5% (53/236) **ENT: 26.9%** (343/1274)	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, and excludes transfer between sites)* *Latest data month: March 2021*	MV: 285 min LG: 226 min **Ent: 256 min**	MV: 290 min LG: 240 min **Ent: 265 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 February 2021

*** SSER data available up to January, FYTD data are displayed as a rate per 10,000 Acute Adjusted Patient Days (EPSI report)

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality, Patient Care, and Patient Experience Committee
From: Stephanie Iljin, Supervisor of Executive Administration
Date: May 3, 2021
Subject: Report on Board Actions

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

Summary:

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

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	April 7, 2021	- Resolution 2021-03: Board Recognition of the COVID-19 Vaccination Program Team - Quality Committee Report - FY21 Period 7 and 8 Financials - Resolution 2021-04: Temporary Suspension of El Camino Hospital Bylaws Article VIII. Section 8.3 - Revised Board Officer Nomination & Selection Procedures - Closed Session Quality Committee Report including Credentials and Privileges Report & Quality Council Minutes - Annual Summary of Physician Financial Arrangements - Closed Session Minutes of the Hospital Board Meeting (3/10/2021) - Executive Compensation Committee Closed Session Minutes (11/05/20) - Medical Staff Report - Open Session of the Hospital Board Meeting (3/10/2021) - Revised FY21 Advisory Committee Assignments - Letters of Reasonableness - Executive Compensation Open Session Meeting Minutes (11/5/2020) - Urology Call Panel - Acute Rehab Professional Services Agreement and Community Benefit Grant

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
	April 14, 2021	N/A
	April 28, 2021	N/A
ECHD Board	April 7, 2021	- Resolution 2021-06: Temporary Suspension of El Camino Hospital Bylaws Article VIII. Section 8.3
Executive Compensation Committee		N/A
Compliance and Audit Committee	March 18, 2021	- Open Session of the CAC Meeting (1/28/2021) - FY22 Committee Meeting Dates - FY22 Committee Goals - Closed Session of the CAC Meeting (1/28/2021)
Finance Committee	March 29, 2021	- Open Session Minutes of the Finance Committee (1/25/2021) - Open Session Minutes of the Joint Finance and Investment Committees (1/25/2021) - FY21 Period 7 and 8 Financial Report - FY22 Committee Meeting Dates - Progress Against FY21 Committee Goals - FY21 Community Benefit Grant - Closed Session Minutes of the Finance Committee (1/25/2021) - Closed Session Minutes of the Joint Finance and Investment Committees (1/25/2021) - LG Urology Call Panel Renewal - LG Acute Rehab Professional Services Agreement Renewal
	April 26, 2021	- Open Session of the Finance Committee (03/29/2021) - FY21 Period 9 Financials - Closed Session of the Finance Committees (03/29/2021)

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	

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

Revised October 5, 2020 **FY21 Pacing Plan**

FY2021 Q1		
JULY 2020	**AUGUST 3, 2020**	**SEPTEMBER 8, 2020**
No Committee Meeting **Routine (Always) Consent Calendar Items:** ▪ **Approval of Minutes** ▪ **FY 21 Quality Dashboard** ▪ **Progress Against FY 2021 Committee Goals (Quarterly)** ▪ **FY21 Pacing Plan (Quarterly)** ▪ **Med Staff Quality Council Minutes (Closed Session)** ▪ **Hospital Update**	Standing Agenda Items: 1. Report on Board Actions 2. Consent Calendar (PSI Report) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items 1. Q4 FY20 Quarterly Quality and Safety Review 2. Quarterly Board Dashboard Review 3. EL Camino Health Medical Network Report 4. Recommend FY21 Organizational Goal Metrics	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (ED Patient Satisfaction) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report QC Follow-Up Items Special Agenda items: 7. Annual Patient Safety Report 8. Pt. Experience (HCAHPS) 9. Progress on Quality and Safety Plan
FY2021 Q2		
OCTOBER 5, 2020	**NOVEMBER 2, 2020**	**DECEMBER 7, 2020**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Report on Medical Staff Peer Review Process 8. FY21 Org. Goal and Quality Dashboard Metrics 9. FY20 Organizational Goal Achievement (Quality, Safety, HCAHPS) (If needed) 10. FY20 Quality Dashboard Final Results	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (CDI Dashboard, Core Measures) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Safety Report for the Environment of Care 8. Q1 FY21 Quarterly Quality and Safety Review 9. Quarterly Board Dashboard Review 10. EL Camino Health Medical Network Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda items: 7. Readmission Dashboard 8. PSI Report 9. Progress on Quality and Safety Plan 10. Systematic Approach to Triggers for Adding Back in Metrics for Review

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

Revised October 5, 2020 **FY21 Pacing Plan**

FY2021 Q3		
JANUARY 2021	**FEBRUARY 1, 2021**	**MARCH 1, 2021**
No Committee Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Q2 FY21 Quality and Safety Review 8. EL Camino Health Medical Network Report 9. Quarterly Board Quality Dashboard Review 10. Health Equity	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up items Special Agenda Items: 7. Proposed FY22 Committee Goals 8. Update on LEAN Transformation 9. Progress on Quality and Safety Plan
FY2021 Q4		
APRIL 5, 2021	**MAY 3, 2021**	**JUNE 1, 2021**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up items Special Agenda Items: 7. Value Based Purchasing Report 8. Pt. Experience (HCAHPS) 9. Approve FY22 Committee Goals 10. Proposed FY22 Committee Meeting Dates 11. Proposed FY22 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar(CDI Dashboard, Core Measures) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow Up Items Special Agenda Items: 7. Proposed FY22Pacing Plan 8. Q3 FY21 Quality and Safety Review 9. Proposed FY22 Organizational Goals 10. EL Camino Health Medical Network Report 11. Quarterly Board Quality Dashboard Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (Leapfrog) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Readmission Dashboard 8. PSI Report 9. Approve FY22 Pacing Plan 10. Medical Staff Credentialing Process 11. Progress on Quality and Safety Plan 12. Finalize FY22 Organizational Goals 13. Quality Assessment and Performance Improvement Plan (QAPI)

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Labor Induction versus Expectant Management in Low-Risk Nulliparous Women

William A. Grobman, M.D., Madeline M. Rice, Ph.D., Uma M. Reddy, M.D., M.P.H., Alan T.N. Tita, M.D., Ph.D., Robert M. Silver, M.D., Gail Mallett, R.N., M.S., C.C.R.C., Kim Hill, R.N., B.S.N., Elizabeth A. Thom, Ph.D., Yasser Y. El-Sayed, M.D., Annette Perez-Delboy, M.D., Dwight J. Rouse, M.D., George R. Saade, M.D., Kim A. Boggess, M.D., Suneet P. Chauhan, M.D., Jay D. Iams, M.D., Edward K. Chien, M.D., Brian M. Casey, M.D., Ronald S. Gibbs, M.D., Sindhu K. Srinivas, M.D., M.S.C.E., Geeta K. Swamy, M.D., Hyagriv N. Simhan, M.D., and George A. Macones, M.D., M.S.C.E., for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal–Fetal Medicine Units Network*

ABSTRACT

BACKGROUND

The perinatal and maternal consequences of induction of labor at 39 weeks among low-risk nulliparous women are uncertain.

METHODS

In this multicenter trial, we randomly assigned low-risk nulliparous women who were at 38 weeks 0 days to 38 weeks 6 days of gestation to labor induction at 39 weeks 0 days to 39 weeks 4 days or to expectant management. The primary outcome was a composite of perinatal death or severe neonatal complications; the principal secondary outcome was cesarean delivery.

RESULTS

A total of 3062 women were assigned to labor induction, and 3044 were assigned to expectant management. The primary outcome occurred in 4.3% of neonates in the induction group and in 5.4% in the expectant-management group (relative risk, 0.80; 95% confidence interval [CI], 0.64 to 1.00). The frequency of cesarean delivery was significantly lower in the induction group than in the expectant-management group (18.6% vs. 22.2%; relative risk, 0.84; 95% CI, 0.76 to 0.93).

CONCLUSIONS

Induction of labor at 39 weeks in low-risk nulliparous women did not result in a significantly lower frequency of a composite adverse perinatal outcome, but it did result in a significantly lower frequency of cesarean delivery. (Funded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development; ARRIVE ClinicalTrials.gov number, NCT01990612.)

The authors' affiliations are listed in the Appendix. Address reprint requests to Dr. Grobman at the Department of Obstetrics and Gynecology, Northwestern University, 250 E. Superior St., Suite 05-2175, Chicago, IL 60611, or at w-grobman@northwestern.edu.

*A list of other members of the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal–Fetal Medicine Units Network is provided in the Supplementary Appendix, available at NEJM.org.

N Engl J Med 2018;379:513-23.
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A Quick Take is available at NEJM.org

Recommendations regarding the timing of delivery are founded on a balancing of maternal and perinatal risks. Delivery before 39 weeks 0 days of gestation without medical indication is associated with worse perinatal outcomes than delivery at full term.[1] For women who are at 41 weeks of gestation or later, delivery has been recommended because of increasing perinatal risks.[2] When gestation is between 39 weeks 0 days and 40 weeks 6 days, common practice has been to avoid elective labor induction because of a lack of evidence of perinatal benefit and concern about a higher frequency of cesarean delivery and other possible adverse maternal outcomes, particularly among nulliparous women.[3]

However, these conclusions were derived largely from observational studies in which labor induction was compared with spontaneous labor.[4-6] Such a comparison provides little insight into clinical management, because spontaneous labor is not a certain alternative to labor induction. Most observational studies that have used the clinically relevant comparator of expectant management have not shown a higher risk of adverse outcomes with labor induction; instead, some of these studies have shown that induction of labor resulted in a lower frequency of cesarean delivery and more favorable perinatal outcomes than expectant management.[7-11]

A previous randomized trial conducted in the United Kingdom compared labor induction at 39 weeks of gestation with expectant management among 619 women who were 35 years of age or older and who had no other indication for delivery at 39 weeks of gestation.[12] The frequency of cesarean delivery was similar in the two groups (relative risk, 0.99; 95% confidence interval [CI], 0.87 to 1.14), although several aspects of the trial, including a rate of operative vaginal delivery (i.e., vaginal delivery with the use of forceps or vacuum) of more than 30%, called into question the external validity of these results for the United States. The authors of that trial encouraged replication of their findings in other populations and the performance of a trial with a sample size sufficient "to test the effects of induction on . . . uncommon adverse neonatal outcomes." The ARRIVE trial (A Randomized Trial of Induction Versus Expectant Management) was designed to test the hypothesis that elective induction of labor at 39 weeks would result in a lower risk of a composite outcome of perinatal death or severe neonatal complications than expectant management among low-risk nulliparous women.

METHODS

TRIAL OVERSIGHT

We conducted this multicenter, randomized, controlled, parallel-group, unmasked trial at 41 hospitals participating in the Maternal–Fetal Medicine Units Network of the Eunice Kennedy Shriver National Institute of Child Health and Human Development. The protocol (available with the full text of this article at NEJM.org) was approved by the institutional review board at each hospital before participant enrollment. Written informed consent was obtained from all participants before randomization. An independent data and safety monitoring committee monitored the trial. The authors vouch for the accuracy and completeness of the data and for the fidelity of the trial to the protocol.

SCREENING AND RECRUITMENT

Low-risk nulliparous women who were at 34 weeks 0 days to 38 weeks 6 days of gestation with a live singleton fetus that was in a vertex presentation, who had no contraindication to vaginal delivery, and who had no cesarean delivery planned were screened for eligibility. Low risk was defined as the absence of any condition considered to be a maternal or fetal indication for delivery before 40 weeks 5 days (e.g., hypertensive disorders of pregnancy or suspected fetal-growth restriction). Reliable information on the length of gestation was also a criterion for enrollment; information was considered to be reliable if the woman was certain of the date of her last menstrual period and that date was consistent with results of ultrasonography performed before 21 weeks 0 days or if the date of the last menstrual period was uncertain but results were available from ultrasonography performed before 14 weeks 0 days. Full eligibility criteria are provided in the Supplementary Appendix, available at NEJM.org.

RANDOMIZATION AND MANAGEMENT STRATEGY

Women who consented to participate were assessed again between 38 weeks 0 days and 38 weeks 6 days of gestation to ensure that they did not have new indications for delivery that would make them ineligible for the trial. Women who

were in labor or had premature rupture of membranes or vaginal bleeding at this time were considered to be ineligible. Women who met the inclusion criteria were randomly assigned in a 1:1 ratio to either labor induction or expectant management. The randomization sequence, prepared by an independent data coordinating center, used the simple urn method, with stratification according to clinical site.[13] The cervix was examined before labor, from 72 hours before to 24 hours after randomization, to assess dilation, effacement, and station of the fetus to determine a modified Bishop score (scores range from 0 to 12, with lower scores associated with a higher chance of cesarean delivery) (see the Supplementary Appendix).[14]

Women in the induction group were assigned to undergo induction of labor at 39 weeks 0 days to 39 weeks 4 days. Women in the expectant-management group were asked to forego elective delivery before 40 weeks 5 days and to have delivery initiated no later than 42 weeks 2 days. A specific induction protocol was not mandated for women who underwent induction in either group. Other protocol guidelines are provided in the Supplementary Appendix.

Trained and certified research staff members abstracted information from medical records, including demographic information, medical history, and outcome data. Participants were followed up with an interview performed by research personnel immediately post partum. During this interview, women were asked to rate their labor pain on a 10-point Likert scale (with higher scores indicating greater pain)[15] and to rate their experiences on the Labor Agentry Scale,[16] which was designed to assess expectations and experiences of personal control during childbirth (scores range from 29 to 203, with higher scores indicating greater perceived control during childbirth). The score on the Labor Agentry Scale was also assessed in a second interview performed by research personnel 4 to 8 weeks after delivery.

TRIAL OUTCOMES

The primary outcome was a composite of perinatal death or severe neonatal complications and consisted of one or more of the following during the antepartum or intrapartum period or during the delivery hospitalization: perinatal death, the need for respiratory support within 72 hours after birth, Apgar score of 3 or less at 5 minutes, hypoxic–ischemic encephalopathy,[17] seizure, infection (confirmed sepsis or pneumonia), meconium aspiration syndrome, birth trauma (bone fracture, neurologic injury, or retinal hemorrhage), intracranial or subgaleal hemorrhage, or hypotension requiring vasopressor support. The principal prespecified maternal outcome (the main secondary outcome) was cesarean delivery.

Prespecified subgroups for the primary perinatal outcome and for the secondary outcome of cesarean delivery were maternal race or ethnic group as reported by the participant (white, black, Asian, Hispanic, other, unknown, or more than one race), age of 35 years or older versus younger than 35 years, body-mass index (the weight in kilograms divided by the square of the height in meters) of 30 or more versus less than 30, and a modified Bishop score at the time of randomization of less than 5 versus 5 or higher. In addition, although it was not a baseline variable, the specialty of the admitting provider (obstetrics–gynecology, maternal–fetal medicine, family practice, or midwifery) was prespecified for the subgroup analyses.

Neonatal secondary outcomes included birth weight, duration of respiratory support, cephalohematoma, shoulder dystocia, transfusion of blood products, hyperbilirubinemia requiring phototherapy or exchange transfusion, hypoglycemia requiring intravenous therapy, admission to the neonatal intermediate or intensive care unit, and length of hospitalization. In addition to cesarean delivery, other maternal secondary outcomes included hypertensive disorders of pregnancy (gestational hypertension or preeclampsia), indication for cesarean delivery, operative vaginal delivery, indication for operative vaginal delivery, uterine incisional extensions during cesarean delivery, chorioamnionitis, third-degree or fourth-degree perineal laceration, postpartum hemorrhage, postpartum infection, venous thromboembolism, number of hours in the labor and delivery unit, length of postpartum hospital stay, admission to the intensive care unit, and maternal death. Definitions of secondary outcomes are provided in the Supplementary Appendix.

Records of all infants who met the primary perinatal outcome were reviewed centrally to verify that the primary outcome had occurred. Records of infants in whom the primary outcome did not occur but that suggested (on the basis of a delivery hospitalization of 7 or more days or discharge to a long-term care facility) that clinically significant perinatal complications may have occurred were reviewed centrally as

well. Reviewers were unaware of the trial-group assignments.

STATISTICAL ANALYSIS

The expected rate of the primary perinatal outcome in the expectant-management group was estimated to be 3.5%.[18] We calculated that enrollment of 6000 women would provide a power of at least 85% to detect a 40% lower rate of the primary outcome in the induction group than in the expectant-management group, at a two-sided type I error rate of 5%. This power analysis incorporated the assumption that for 7.5% of the women, management would not be consistent with the protocol of the assigned strategy.

Analyses were performed according to the intention-to-treat principle. We compared continuous variables using the Wilcoxon signed-rank test and categorical variables using the chi-square and Fisher's exact tests. A multinomial outcome was compared with the use of multinomial logistic regression. Time variables measured in days were categorized and compared with the Cochran–Armitage trend test. We used a group sequential method to control the type I error with the Lan–DeMets characterization of the O'Brien–Fleming boundary. One interim analysis was performed; in the final analysis of the primary outcome, a two-tailed P value of less than 0.046 was considered to indicate statistical significance. Because the adjustment is minimal, we report the 95% confidence interval for the relative risk. Our statistical analysis plan did not call for adjustment of P values to control for multiple comparisons of the results for the individual components of the primary outcome; therefore, these are reported as point estimates and 95% confidence intervals. For the secondary outcomes, the level of significance was adjusted post hoc for multiple comparisons with the false discovery rate method.[19] No method of imputation of missing data was used, although sensitivity analyses were performed in which data from participants who withdrew consent or were lost to follow-up were handled in various ways. To determine whether there was a differential effect of labor induction on the primary perinatal outcome and on the secondary outcome of cesarean delivery within the prespecified subgroups, we performed the Breslow–Day interaction test in which a P value of less than 0.05 was considered to indicate statistical significance. The statistical analysis plan is provided in the protocol, available at NEJM.org.

RESULTS

CHARACTERISTICS OF THE PARTICIPANTS

From March 2014 through August 2017, a total of 50,581 women underwent screening for eligibility. Of the 22,533 eligible women, 6106 (27%) provided written informed consent and underwent randomization: 3062 were assigned to the induction group, and 3044 to the expectant-management group (Fig. 1). At the time of randomization, 63% of the participants had an unfavorable modified Bishop score (i.e., a score <5). The two groups were similar at baseline, except that fewer women in the induction group than in the expectant-management group had had a previous pregnancy loss (22.8% vs. 25.6%, P=0.01) (Table 1). The obstetrical provider at the time of admission for delivery was a physician for 94% of women and a midwife for 6%.

ADHERENCE

Three women in the induction group and 7 in the expectant-management group were lost to follow-up or withdrew consent. In the case of 184 women (6.0%) in the induction group and 140 (4.6%) in the expectant-management group, the management was not consistent with the protocol of the assigned strategy (details are provided in the Supplementary Appendix). Women in the induction group had a shorter median time from randomization to delivery than women in the expectant-management group (7 days [interquartile range, 5 to 9] vs. 12 days [interquartile range, 7 to 16], P<0.001); in addition, women in the induction group underwent delivery at a significantly earlier median gestational age (39.3 weeks [interquartile range, 39.1 to 39.6] vs. 40.0 weeks [interquartile range, 39.3 to 40.7], P<0.001) and had neonates with significantly lower median birth weights (3300 g [interquartile range, 3040 to 3565] vs. 3380 g [interquartile range, 3110 to 3650], P<0.001).

PRIMARY OUTCOME AND OTHER PERINATAL OUTCOMES

The primary perinatal outcome occurred in 4.3% of the neonates in the induction group and in 5.4% in the expectant-management group (relative risk, 0.80; 95% CI, 0.64 to 1.00; P=0.049

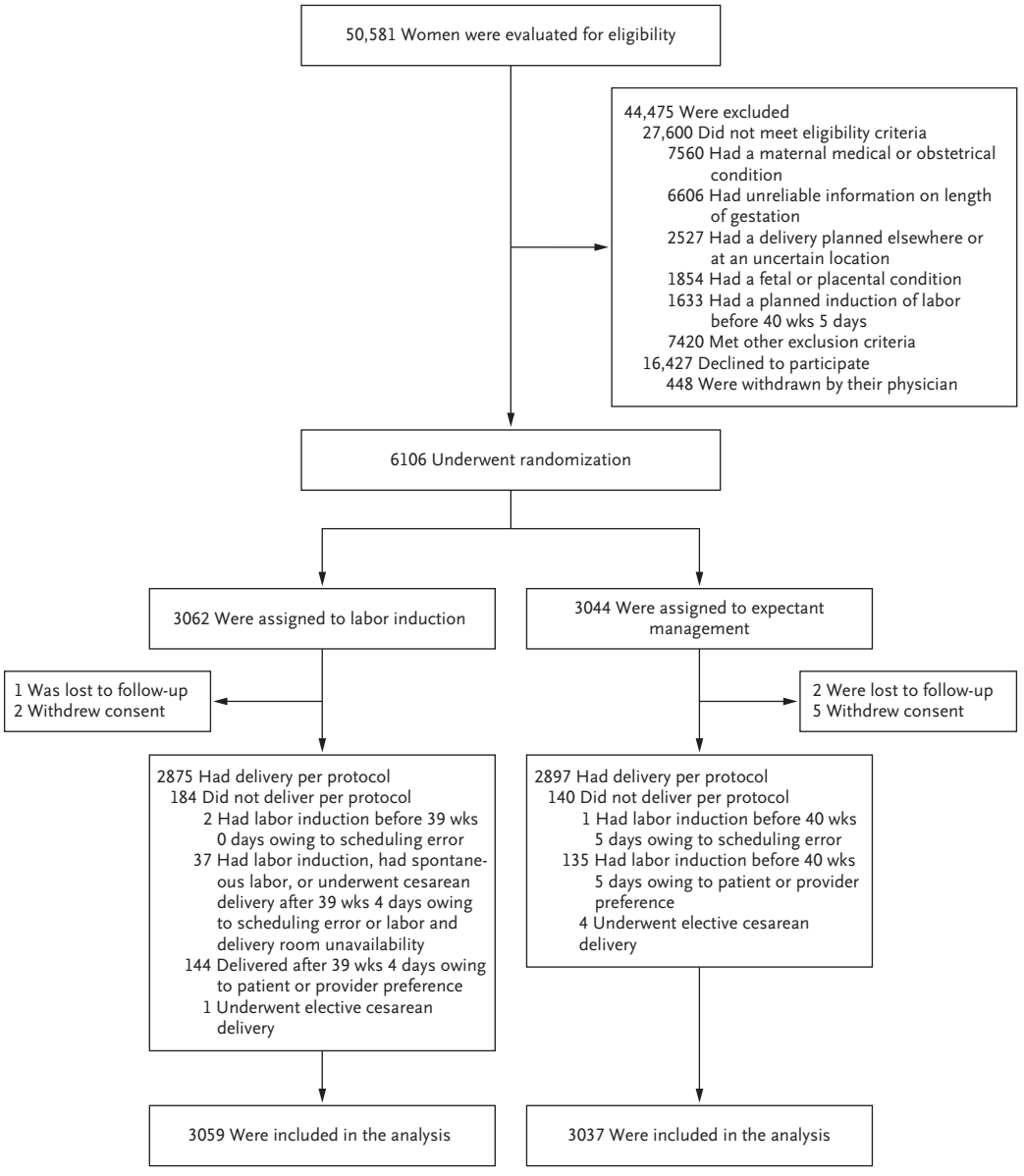


Figure 1. Eligibility, Randomization, Delivery, and Assessment.

Per-protocol delivery in the induction group was defined as electively induced labor from 39 weeks 0 days to 39 weeks 4 days or spontaneous labor or medically indicated delivery on or before 39 weeks 4 days (this also included delivery delayed past 39 weeks 4 days because of a new medical indication that had developed). Per-protocol delivery in the expectant-management group was defined as induction from 40 weeks 5 days to 42 weeks 2 days or spontaneous or medically indicated delivery on or before 42 weeks 2 days.

[P<0.046 indicated statistical significance for the primary perinatal outcome]) (Table 2). This finding did not change after adjustment for previous pregnancy loss and was materially unchanged in the sensitivity analyses. Neonates in the induction group also had a shorter duration of respiratory support and of total hospital stay. Other secondary perinatal outcomes were similar in the two groups (see the Supplementary Appendix).

Table 1. Maternal Characteristics at Baseline.*

Characteristic	Induction Group (N=3062)	Expectant-Management Group (N=3044)
Age — yr		
Median	24	23
Interquartile range	21–28	20–28
Age ≥35 yr — no. (%)	114 (3.7)	136 (4.5)
Race or ethnic group — no. (%)†		
White	1329 (43.4)	1359 (44.6)
Black	707 (23.1)	699 (23.0)
Asian	87 (2.8)	106 (3.5)
Hispanic	866 (28.3)	808 (26.5)
Other, unknown, or more than one race	73 (2.4)	72 (2.4)
Married or living with a partner — no. (%)	1814 (59.2)	1798 (59.1)
Employment status — no./total no. (%)‡		
Employed full time	1226/3053 (40.2)	1209/3036 (39.8)
Employed part time	341/3053 (11.2)	353/3036 (11.6)
Not employed	1486/3053 (48.7)	1474/3036 (48.6)
Had private insurance for prenatal care — no./total no. (%)§	1404/3061 (45.9)	1335/3044 (43.9)
History of pregnancy loss — no. (%)		
No previous pregnancy loss	2364 (77.2)	2266 (74.4)
Previous pregnancy loss	698 (22.8)	778 (25.6)
Before 13 wk of gestation only	637 (20.8)	698 (22.9)
At 13–19 wk of gestation only	23 (0.8)	40 (1.3)
Both before 13 wk and at 13–19 wk of gestation	14 (0.5)	17 (0.6)
Ectopic or molar pregnancy only	24 (0.8)	21 (0.7)
Uncertain time of pregnancy loss	0	2 (0.1)
Length of gestation at randomization — wk		
Median	38.3	38.3
Interquartile range	38.0–38.6	38.0–38.6
Method of conception — no. (%)		
In vitro fertilization	56 (1.8)	47 (1.5)
Ovulation induction or artificial insemination	30 (1.0)	24 (0.8)
Spontaneous	2976 (97.2)	2973 (97.7)
Smoked cigarettes — no. (%)	224 (7.3)	242 (8.0)
Drank alcohol — no./total no. (%)¶	133/3062 (4.3)	107/3043 (3.5)
BMI at randomization‖		
Median	30.5	30.3
Interquartile range	27.3–34.6	27.3–35.0
BMI ≥30 — no./total no. (%)‖	1632/3049 (53.5)	1575/3027 (52.0)
Modified Bishop score at randomization**		
Median	4	4
Interquartile range	2–5	2–5
Score <5 — no./total no. (%)**	1919/3062 (62.7)	1954/3042 (64.2)

* There were no significant differences between the groups except for previous pregnancy loss, which was less common in the induction group (P=0.01). Percentages may not total 100 because of rounding.
† Race or ethnic group was reported by the participant.
‡ Data are missing for 17 women (9 in the induction group and 8 in the expectant-management group).
§ Data are missing for 1 woman in the induction group.
¶ Data are missing for 1 woman in the expectant-management group.
‖ The body-mass index (BMI) is the weight in kilograms divided by the square of the height in meters. Data are missing for 30 women (13 in the induction group and 17 in the expectant-management group).
** Modified Bishop scores range from 0 to 12, with lower scores associated with a higher chance of cesarean delivery. Data are missing for 2 women in the expectant-management group.

Table 2. Primary Perinatal Outcome and Components.*

Outcome	Induction Group (N=3059)	Expectant-Management Group (N=3037)	Relative Risk (95% CI)†	P Value‡
	no. (%)			
Primary composite outcome	132 (4.3)	164 (5.4)	0.80 (0.64–1.00)	0.049
Perinatal death	2 (0.1)	3 (0.1)	0.66 (0.12–3.33)	
Respiratory support	91 (3.0)	127 (4.2)	0.71 (0.55–0.93)	
Apgar score ≤3 at 5 min	12 (0.4)	18 (0.6)	0.66 (0.32–1.37)	
Hypoxic–ischemic encephalopathy	14 (0.5)	20 (0.7)	0.70 (0.35–1.37)	
Seizure	11 (0.4)	4 (0.1)	2.74 (0.91–8.12)	
Infection	9 (0.3)	12 (0.4)	0.74 (0.31–1.76)	
Meconium aspiration syndrome	17 (0.6)	26 (0.9)	0.65 (0.35–1.19)	
Birth trauma	14 (0.5)	18 (0.6)	0.77 (0.38–1.55)	
Intracranial or subgaleal hemorrhage	9 (0.3)	7 (0.2)	1.28 (0.48–3.42)	
Hypotension requiring vasopressor support	2 (0.1)	5 (0.2)	0.40 (0.06–1.79)	

* Details regarding the components of the primary perinatal outcome are provided in the Supplementary Appendix.
† Exact confidence intervals are provided for rare outcomes. The widths of the confidence intervals for components of the primary outcome have not been adjusted for multiplicity, so they should not be used to infer definitive effects of the management strategies.
‡ We used a group sequential method to control the type I error with the Lan–DeMets characterization of the O'Brien–Fleming boundary. One interim analysis was performed; in the final analysis of the primary outcome, a two-tailed P value of less than 0.046 was considered to indicate statistical significance. Since the adjustment is minimal, we report the 95% confidence interval for the relative risk.

MATERNAL OUTCOMES

The percentage of women who underwent cesarean delivery was significantly lower in the induction group than in the expectant-management group (18.6% vs. 22.2%; relative risk, 0.84; 95% CI, 0.76 to 0.93; P<0.001) (Table 3). This finding did not change materially after adjustment for previous pregnancy loss. Women assigned to induction of labor were also significantly less likely than women assigned to expectant management to have hypertensive disorders of pregnancy (9.1% vs. 14.1%; relative risk, 0.64; 95% CI, 0.56 to 0.74; P<0.001) and to have extensions of the uterine incision during cesarean delivery; in addition, women in the induction group reported less pain (i.e., had lower scores on the 10-point Likert scale) and more perceived control during childbirth (i.e., had higher scores on the Labor Agentry Scale). Although differences in scores were statistically significant, they were relatively small. Women in the induction group spent more time in the labor and delivery unit, but the length of their postpartum hospital stay was shorter (Table 3). Other secondary maternal health outcomes were similar in the two groups (see the Supplementary Appendix).

SUBGROUP ANALYSES

Prespecified baseline subgroup analyses of the primary perinatal outcome and of the secondary outcome of cesarean delivery showed no significant differences in results according to race or ethnic group, maternal age, body-mass index, or modified Bishop score (all P>0.05 by the Breslow–Day test for homogeneity) (Fig. 2). Subgroup analysis also revealed no significant between-group difference in the two outcomes according to type of admitting provider.

DISCUSSION

In this randomized trial involving low-risk nulliparous women, we did not find a significant difference in the frequency of the primary outcome (a composite of adverse perinatal outcomes) between women randomly assigned to labor induction at 39 weeks of gestation and women assigned to expectant management. Nevertheless,

Table 3. Secondary Outcomes.*

Outcome	Induction Group (N=3059)	Expectant-Management Group (N=3037)	Relative Risk (95% CI)	P Value
Neonatal				
Transfusion of blood products — no. (%)	4 (0.1)	5 (0.2)	0.79 (0.20–2.74)	0.75
Hyperbilirubinemia — no. (%)†	145 (4.7)	142 (4.7)	1.01 (0.81–1.27)	0.91
Hypoglycemia — no. (%)	37 (1.2)	35 (1.2)	1.05 (0.66–1.66)	0.84
Admission to neonatal intermediate or intensive care unit — no. (%)	358 (11.7)	394 (13.0)	0.90 (0.79–1.03)	0.13
Maternal				
Cesarean delivery — no. (%)	569 (18.6)	674 (22.2)	0.84 (0.76–0.93)	<0.001‡
Operative vaginal delivery — no. (%)	222 (7.3)	258 (8.5)	0.85 (0.72–1.01)	0.07
Hypertensive disorder of pregnancy — no. (%)	277 (9.1)	427 (14.1)	0.64 (0.56–0.74)	<0.001‡
Chorioamnionitis — no. (%)	407 (13.3)	429 (14.1)	0.94 (0.83–1.07)	0.35
Third-degree or fourth-degree perineal laceration — no. (%)	103 (3.4)	89 (2.9)	1.15 (0.87–1.52)	0.33
Postpartum hemorrhage — no. (%)	142 (4.6)	137 (4.5)	1.03 (0.82–1.29)	0.81
Postpartum infection — no. (%)	50 (1.6)	65 (2.1)	0.76 (0.53–1.10)	0.15
Admission to ICU — no. (%)	4 (0.1)	8 (0.3)	0.50 (0.13–1.55)	0.26
Death — no. (%)	0	0	NA	NA
Median duration of stay in labor and delivery unit (IQR) — hr§	20 (13–28)	14 (9–20)		<0.001‡
Postpartum hospital stay — no. (%)				0.01‡¶
<2 days	322 (10.5)	317 (10.4)		
2 days	2191 (71.6)	2084 (68.6)		
3 days	399 (13.0)	452 (14.9)		
4 days	130 (4.2)	166 (5.5)		
>4 days	17 (0.6)	18 (0.6)		
Median scores on Labor Agentry Scale (IQR)‖				
At 6–96 hr after delivery	168 (148–183)	164 (143–181)		<0.001‡
At 4–8 wk after delivery	176 (157–189)	174 (154–188)		0.01‡
Median labor pain scores (IQR)**				
Worst score	8 (7–10)	9 (8–10)		<0.001‡
Overall score	7 (5–8)	7 (5–9)		<0.001‡

* Additional secondary outcomes are provided in the Supplementary Appendix. Exact confidence intervals and P values are provided for rare outcomes. The P values and 95% confidence intervals presented have not been adjusted for multiple comparisons of the secondary outcomes. ICU denotes intensive care unit, IQR interquartile range, and NA not applicable.

† Data are missing for 4 women (1 in the induction group and 3 in the expectant-management group).

‡ The P value remained significant after controlling for multiple comparisons with the false discovery rate method.

§ The totals exclude 7 women who delivered before admission to the labor and delivery unit. Data are missing for 2 women (1 in each group).

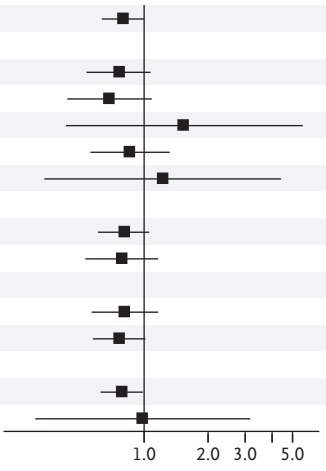
¶ The variables were compared with the Cochran–Armitage trend test.

‖ Scores on the Labor Agentry Scale range from 29 to 203, with higher scores indicating greater perceived control during childbirth; included are women who had spontaneous labor, labor that started spontaneously but then was augmented, or induced labor. Data for 6 to 96 hours after delivery are missing for 288 women (127 in the induction group and 161 in the expectant-management group); data for 4 to 8 weeks after delivery are missing for 736 women (349 in the induction group and 387 in the expectant-management group).

** Labor pain was scored according to a 10-point Likert scale, with higher scores indicating greater pain; included are women who had spontaneous labor, labor that started spontaneously but then was augmented, or induced labor. Data on worst score are missing for 274 women (110 in the induction group and 164 in the expectant-management group); data on overall score are missing for 275 women (110 in the induction group and 165 in the expectant-management group).

A Primary Perinatal Outcome

Subgroup	No. of Patients	No. with Outcome	Relative Risk (95% CI)	P Value for Interaction
Overall	6096	296	0.80 (0.64–1.00)	
Race or ethnic group				0.72
White	2685	126	0.77 (0.54–1.08)	
Black	1404	73	0.69 (0.44–1.09)	
Asian	192	9	1.54 (0.43–5.56)	
Hispanic	1670	79	0.86 (0.56–1.32)	
Other	145	9	1.23 (0.34–4.41)	
Modified Bishop score				0.93
<5	3868	199	0.81 (0.61–1.06)	
≥5	2226	97	0.79 (0.53–1.17)	
BMI				0.77
<30	2865	117	0.82 (0.57–1.17)	
≥30	3201	178	0.77 (0.58–1.02)	
Age				0.70
<35 yr	5846	285	0.79 (0.63–0.99)	
≥35 yr	250	11	0.99 (0.31–3.17)	



B Cesarean Delivery

Subgroup	No. of Patients	No. with Outcome	Relative Risk (95% CI)	P Value for Interaction
Overall	6096	1243	0.84 (0.76–0.93)	
Race or ethnic group				0.23
White	2685	472	0.76 (0.64–0.89)	
Black	1404	320	0.83 (0.68–1.01)	
Asian	192	53	0.75 (0.46–1.20)	
Hispanic	1670	366	0.93 (0.77–1.11)	
Other	145	32	1.44 (0.77–2.70)	
Modified Bishop score				1.00
<5	3868	940	0.85 (0.76–0.95)	
≥5	2226	302	0.83 (0.67–1.03)	
BMI				0.10
<30	2865	393	0.72 (0.60–0.87)	
≥30	3201	845	0.89 (0.79–1.00)	
Age				0.51
<35 yr	5846	1152	0.85 (0.76–0.94)	
≥35 yr	250	91	0.78 (0.56–1.10)	

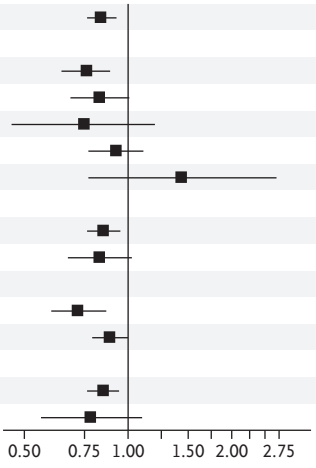


Figure 2. Prespecified Subgroup Analyses According to Maternal Baseline Variables.

The primary outcome was a composite of perinatal death or severe neonatal complications and consisted of one or more of the following during the antepartum or intrapartum period or during the delivery hospitalization: perinatal death, the need for respiratory support within the first 72 hours after birth, Apgar score of 3 or less at 5 minutes, hypoxic–ischemic encephalopathy, seizure, infection (confirmed sepsis or pneumonia), meconium aspiration syndrome, birth trauma (bone fracture, neurologic injury, or retinal hemorrhage), intracranial or subgaleal hemorrhage, or hypotension requiring vasopressor support. Race was reported by the participant; "other" race or ethnic group includes other, unknown, or more than one race or ethnic group. Modified Bishop scores range from 0 to 12, with lower scores associated with a higher chance of cesarean delivery. The body-mass index (BMI) is the weight in kilograms divided by the square of the height in meters.

the relative risk was 20% lower in the induction group than in the expectant-management group, and the corresponding 95% confidence interval suggests that labor induction is probably not associated with a higher risk of adverse perinatal outcomes than expectant management, and it may be associated with as much as a 36% lower risk than expectant management. Labor induction also resulted in a significantly lower frequency of cesarean delivery and hypertensive

disorders of pregnancy than expectant management, even after post hoc adjustment for multiplicity. Our data suggest that 1 cesarean delivery may be avoided for every 28 deliveries among low-risk nulliparous women who plan to undergo elective induction of labor at 39 weeks.

These findings contradict the conclusions of multiple observational studies that have suggested that labor induction is associated with an increased risk of adverse maternal and perinatal outcomes.[4-6] These studies, however, compared women who underwent labor induction with those who had spontaneous labor, which is not a comparison that is useful to guide clinical decision making. Conversely, our findings are consistent with observational studies,[7-11,20-23] as well as the randomized trial conducted by Walker et al.,[12] in which women undergoing labor induction were compared with women undergoing the actual clinical alternative of expectant management.

We found no significant difference in the magnitude of effect with respect to the primary perinatal outcome or cesarean delivery according to whether a woman had an unfavorable modified Bishop score at randomization. This finding may seem unexpected, given the consistent evidence that women with an unfavorable Bishop score have a higher chance of cesarean delivery when labor is induced than women with a favorable score.[3] As shown by the frequency of cesarean delivery among women with an unfavorable as opposed to a favorable baseline modified Bishop score (i.e., a score ≥5), this relationship holds true in our trial. Yet, because women with an unfavorable score at baseline also had a higher chance of cesarean delivery than women with a favorable score when they followed the expectant-management strategy, labor induction in women with an unfavorable score still resulted in fewer cesarean deliveries than expectant management.

This trial is larger than previous randomized trials that compared labor induction with expectant management in low-risk women, and as such it had the ability to detect differences that previous trials may not have discerned. Eligibility criteria ensured that only women with reliable information on length of gestation were included, and both women with favorable modified Bishop scores at baseline and those with unfavorable scores were enrolled.

Limitations of the trial should be noted. First, because masking was not feasible, ascertainment bias is possible. Second, despite its size, the trial was not powered to detect differences in infrequent outcomes, and most individual adverse perinatal outcomes were relatively uncommon. Third, it is unclear whether results are broadly generalizable; however, the inclusion of both university and community hospitals throughout the United States and of a variety of types of obstetrical providers, as well as the absence of a single protocol for induction or labor management, suggests that results are probably generalizable to similar centers. Finally, the cost-effectiveness of labor induction in low-risk nulliparous women at 39 weeks will need to be evaluated in further analyses.

In summary, we found that elective labor induction at 39 weeks of gestation did not result in a greater frequency of perinatal adverse outcomes than expectant management and resulted in fewer instances of cesarean delivery. These results suggest that policies aimed at the avoidance of elective labor induction among low-risk nulliparous women at 39 weeks of gestation are unlikely to reduce the rate of cesarean delivery on a population level; the trial provides information that can be incorporated into discussions that rely on principles of shared decision making.[24-27]

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Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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APPENDIX

The authors' affiliations are as follows: the Department of Obstetrics and Gynecology, Northwestern University, Chicago (W.A.G., G.M.); University of Alabama at Birmingham, Birmingham (A.T.N.T.); University of Utah Health Sciences Center, Salt Lake City (R.M.S., K.H.); Stanford University, Stanford, CA (Y.Y.E.-S.); Columbia University, New York (A.P.-D.); Brown University, Providence, RI (D.J.R.); University of Texas Medical Branch, Galveston (G.R.S.), University of Texas Health Science Center at Houston, Children's Memorial Hermann Hospital, Houston (S.P.C.), and University of Texas Southwestern Medical Center, Dallas (B.M.C.) — all in Texas; University of North Carolina at Chapel Hill, Chapel Hill (K.A.B.), and Duke University, Durham (G.K.S.) — both in North Carolina; Ohio State University, Columbus (J.D.I.), and MetroHealth Medical Center, Case Western Reserve University, Cleveland (E.K.C.) — both

in Ohio; University of Colorado School of Medicine, Anschutz Medical Campus, Aurora (R.S.G.); University of Pennsylvania, Philadelphia (S.K.S.); University of Pittsburgh, Pittsburgh (H.N.S.) — both in Pennsylvania; Washington University, St. Louis (G.A.M.); the George Washington University Biostatistics Center, Washington, DC (M.M.R., E.A.T.); and the Eunice Kennedy Shriver National Institute of Child Health and Human Development, Bethesda, MD (U.M.R.).

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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: May 3, 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 Maternal Child Health. The patient expressed concern about her epidural experience and communication from the anesthesiologist. Also, there was concern about time with pediatrician. However, some caregivers did provide a good experience.

2. Authority: To provide insight into one patient's experience.

3. Background: This patient was here to delivery her baby and she experienced unrelieved pain after her epidural was placed. Communication related to the epidural placement and troubleshooting was not clear to the patient. The anesthesiologist who took over care rectified the situation. The patient also wanted more time with the pediatrician.

4. Assessment: The chart was reviewed by the director of anesthesia and found that the clinical quality of care was appropriate. Trouble shooting of the epidural occurred as per policy and protocol and eventually replaced by the oncoming anesthesiologist. Unfortunately, the communication of epidural procedure and all the troubleshooting done and documented in the patient's chart was not communicated clearly to the patient. The pediatrician schedule was also not clearly explained.

5. Other Reviews: None

6. Outcomes: The Medical Director of Anesthesia is contacting the patient and will provide service recovery. In addition, the patient received a follow up phone call after discharge and the schedule for pediatric visits was explained again. This is an example where clear communication of the clinical scenario provided in a way the patient can understand assists with providing patients necessary information.

List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. What is your mechanism for sharing patient feedback with physicians?

2. How do we insure that important communication is provided clearly in a way patient's can understand?

Comment from Press Ganey Survey

April 1, 2021

Comment: Time with doctors was less, except on the last day of discharge where we had more face time with the pediatrician. I expected to be able to see pediatrician at birth or at least after birth, but only child nurse was present at birth and after birth. Only on discharge day, a pediatrician did a thorough check of the baby. Also had a very bad experience with one of the anesthesiologist, whose first name we caught as Ulrik. We asked for epidural while I was 4cm dilated, he came in and did not speak a single word about the procedure. He expected the nurse to tell us anything. He did a very bad job of administering the epidural, because it was effective only on my left side and I could feel all the pain on the right side. Instead of accepting that the epidural was put wrong, he and nurse kept giving me pain killers which were drowsy as well. I suffered almost 4-5hrs in bad pain. Finally the next shift anaesthesiologist, who was a lady, we could not catch her name, she was on duty on March 22nd, 2021 morning, was literally God-sent!! She immediately understood the epidural was put badly and redid the epidural and then I was fine and was able to deliver the baby properly. So please check the quality of your anaesthesiologists. I really hope the anesthesiologist who finally helped us is rewarded well. She is truly our Angel for the day. Also Doctor Tong who delivered our baby, was amazing! She was so available for us, and came on time for our baby delivery. Without the specific anesthesiologist (whose name we didn't catch), Dr. Tong, and nurse Anita, our baby delivery wouldn't have been smooth. We truly thank them from the bottom of our heart.

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: May 3, 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. **Likelihood to Recommend (LTR):** This is a key metric analogous to the Net Promoter Score used by many industries to assess customer experience and to predict future growth.

5. Other Reviews: None

6. Outcomes: The Quality Committee will recommend to the Board that these three quality and one experience strategic goals be adopted for FY21.

List of Attachments: None

Suggested Committee Discussion Questions: Does this make sense and is it consistent with our overall quality strategy?

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

Revised April 26, 2021 **FY22 Pacing Plan**

FY2022 Q1		
JULY 2021	**AUGUST 2, 2021**	**SEPTEMBER 7, 2021**
No Committee Meeting **Routine (Always) Consent Calendar Items:** ▪ **Approval of Minutes** ▪ **FY 22 Quality Dashboard** ▪ **Progress Against FY 2021 Committee Goals (Quarterly)** ▪ **FY22 Pacing Plan (Quarterly)** ▪ **Med Staff Quality Council Minutes (Closed Session)** ▪ **Hospital Update**	Standing Agenda Items: 1. Report on Board Actions 2. Consent Calendar (PSI Report) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items 1. Q4 FY21 Quarterly Quality and Safety Review 2. Quarterly Board Dashboard Review 3. EL Camino Health Medical Network Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (ED Patient Satisfaction) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report QC Follow-Up Items Special Agenda items: 7. Annual Patient Safety Report 8. Pt. Experience (HCAHPS)
FY2022 Q2		
OCTOBER 4, 2021	**NOVEMBER 1, 2021**	**DECEMBER 6, 2021**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Report on Medical Staff Peer Review Process 8. FY22 Org. Goal and Quality Dashboard Metrics 9. FY21 Organizational Goal Achievement (Quality, Safety, HCAHPS) (If needed) 10. FY21 Quality Dashboard Final Results	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (CDI Dashboard, Core Measures) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Safety Report for the Environment of Care 8. Q1 FY22 Quarterly Quality and Safety Review 9. Quarterly Board Dashboard Review 10. EL Camino Health Medical Network Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda items: 7. Readmission Dashboard 8. PSI Report
FY2022 Q3		
JANUARY 2022	**FEBRUARY 7, 2022**	**MARCH 7, 2022**

No Committee Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Q2 FY22 Quality and Safety Review 8. EL Camino Health Medical Network Report 9. Quarterly Board Quality Dashboard Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up items Special Agenda Items: 7. Proposed FY23 Committee Goals
FY2022 Q4		
APRIL 4, 2022	**MAY 2, 2022**	**JUNE 6, 2022**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up items Special Agenda Items: 7. Value Based Purchasing Report 8. Pt. Experience (HCAHPS) 9. Approve FY23 Committee Goals 10. Proposed FY23 Committee Meeting Dates 11. Proposed FY23 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar(CDI Dashboard, Core Measures) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow Up Items Special Agenda Items: 7. Proposed FY23 Pacing Plan 8. Q3 FY22 Quality and Safety Review 9. Proposed FY23 Organizational Goals 10. EL Camino Health Medical Network Report 11. Quarterly Board Quality Dashboard Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (Leapfrog) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Readmission Dashboard 8. PSI Report 9. Approve FY23 Pacing Plan 10. Medical Staff Credentialing Process 11. Progress on Quality and Safety Plan 12. Finalize FY23 Organizational Goals 13. Approve Quality Assessment and Performance Improvement Plan (QAPI)

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Vince Manoogian, Interim President, SVMD
Date: May 3, 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 shows a slight decrease in several measures (BMI, Controlling BP, Hemoglobin A1C and cancer screenings) with a composite score of 3.2 from the previous quarter.

Finally, the Net Promoter Score for ECHMN has shown a steady improvement. NPS 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 FYQ3 NPS score for SVMD is 77.1 compared to 75.7 for FYQ2. Baseline FY20 was 72.3.

5. Outcomes: SVMD has implemented procedural changes, which should increase our scores in BMI, Blood Pressure Control, Breast and colon rectal cancer screening.

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

Suggested Committee Discussion Questions:

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

SVMD Quality Committee Meeting Report
May 3, 2021

SVMD Leading HealthCare Metrics
Target versus Actual as of March 31, 2021

Metric	Target	3rd Qtr	Trend
Composite Score	3	3.2	↓
Documentation of Current Med	89%	93%	↑
BMI Screening and Intervention	47%	36%	↓
Hemoglobin A1C (lower percentage is better)	29%	49%	↑
Breast Cancer Screening	48%	45%	↓
Colorectal Cancer Screening	45%	44%	↓
Tobacco Screening and Intervention	90%	94%	~
Fall Screening	56%	85%	↑
Controlling Blood Pressure	63%	49%	↓

2020 MIPS as of March 31, 2021

- MIPS Calculation will be finalized in August or September by CMS
- The 2020 data was submitted to CMS by February 15, 2021
- The current data shows that SVMD TIN should score at least 85%, which should put SVMD at the exceptional bonus level
  - the cost component has not been finalized; CMS calculates
  - We do not have historical cost data for SJMG
  - We assumed a cost scoring of 66%
- Quality and Promoting Interoperability (PI) components have increased

Quality Committee Updates as of March 31, 2021

- Quality Committee Expanded and Membership has changed and had the first meeting with the new committee members in March, 2021
  - Every location has a representative on the committee
- Credentialing Committee Expanded and Membership has changed; first meeting with the new committee members in March, 2021
  - Credentialing committee reports up to Quality Committee
- New Provider Selection Criteria Policy was approved and implemented
  - Policy is in line with Hospital selection process
- Reviewed Complaints and Grievances for the 1st Quarter

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: May 3, 2021
Subject: Board Quality and Safety Dashboard

Purpose: To review the Q3 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. Mortality index has increased in this quarter with two main drivers noted: COVID-19 patient deaths and advanced sepsis patient deaths refractory to sepsis treatment. 54% of all deaths were attributable to sepsis with 38% of deaths occurring within 48 hours of admission.
- ii. Sepsis mortality index has increased significantly despite improved SEP-1 compliance. The findings of 38% of deaths within 48 hours suggests a higher incidence of end stage sepsis which can be refractory to the standard sepsis bundle application.
- iii. SSER is below target but the Precursor Safety Event numbers of still high.
- iv. C.Diff: 7 cases total; 1 in March which was a failed screening
- v. CLABSI: 2 total; one in LG and one in MV; both in oncology patients; the LG case breaks a greater than 3 year 0 CLABSI record for LG

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. Within the measure there has been improvement in the consult to admit order subset.

C. Effective Care:
- i. Readmission Index increased driven significantly by COVID-19 patients who showed a selective index of 1.40.
- ii. CMS SEP-1 Compliance rate: slight decrease in Q3 to 80.5% but still below internal goal of 86%; (CMS median rate is 60% across all hospitals)
- iii. PC-02 C/S rate: increased again primarily driven by a doubling of the rate in LG and several outlier obstetricians; effect of increased elective inductions being studied.

D. Efficient Care: No issues

E. Equitable Care: No issues

F. Patient-Centered Care:

i. IP enterprise improved but below target. ED slightly decreased, MCH improved but below target, outpatient surgery stable but below target. Visitation as a factor has lessened as some visitation is now permitted. Enhanced patient rounding is being ramped up.

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 Q3.

List of Attachments:

1. Q3 STEEEP dashboard

Suggested Committee Discussion Questions:

1. Are there any questions regarding the "red" metrics?
2. Would the Committee like to use findings on this dashboard to drive agenda items for more in depth reviews going forward?
3. What additional supporting information would be useful to the Committee to assist in evaluating the metrics?
4. 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, Q3 (unless otherwise specified by *)

Quality Domain	Metric	Baseline	Target	Performance				
		FY 20	FY 21	FYTD21, Q1	FYTD21, Q2	FYTD21, Q3	FYTD21, Q4	FYTD21 Total
	Clostridium Difficile Infection (CDI) - HAI	1.46	<= 1.46	1.6	1.43	2.59		1.88
	Modified PSI-90 CMS HAC Reduction Program	0.919	0.90	0.898	0.815	1.034		0.838
Timely	Patient Throughput - ED Door to Admit Order	190 min	181 min	188 min	195 min	196 min		193.5 min
Timely	Patient Throughput - Median Time Arrival to ED Departure	284 min	245 min	255 min	274 min	271 min		265 min
Timely	ED Arrival to Direct Discharge for ED Patients	151 min	145 min	154 min	154 min	162 min		156.5 min
Effective	Risk Adjusted Readmissions Index	0.96	0.93	0.88	0.96	1.03*		0.95
Effective	CMS SEP-1 Compliance Rate	70.9%	86%	67.6%	81.8%	80.5%		77.3%
Effective	PC-01 Elective Delivery Prior to 39 Weeks Gestation	ENT: 1.3%	1.3%	0% (0/70)	1.2% (1/85)	*0% (0/60)		0.47%
Effective	PC-02 NTSV C-Section	ENT: 24.0%	23.5%	27.6% (142/514)	25.8% (120/466)	*27.6% (81/294)		26.9%
Effective	ECMN: CMS 165 Controlling High Blood Pressure	51.20%	<= 63%	58.0%	56.0%	52.0%		57.0%
Effective	ECMN: CMS 122 Diabetes Hemoglobin A1c Poor Control	43.30%	<= 45	27.0%	29.0%	45.0%		33.3%
Effective	HEDIS: Composite	NA	3.0	3.3	3.3	3.2		3.25
Efficient	Arithmetic Observed LOS/ Geometric Expected LOS	1.32	1.30	1.32	1.32	1.31		1.31
Efficient	MSPB-1 Medicare Spending per Beneficiary (CMS)	0.99 (CY 18)	0.99	0.99	None, updated annually in January	1.00		0.99
Equitable	Hospital Charity Care Support	$20.5 mil	NA	$6.6 mil	$5.7 mil	7.4 mil		$19.7 mil
Equitable	Clinic Charity Care Support	$44.3k	NA	$8.4k	1.1k	3.3k		12.9k
Equitable	Language Line Unmet Requests (data collection started Q2)	0.34%	<1%	0.39%	0.64%	1.07%		0.70%
Equitable	Length of Stay Disparity (Top 3 races) 40% patients did not report their race	Black: 4.05	NA	3.98	4.56	4.11		4.13
		White: 3.79		3.81	3.97	3.92		3.93
		Asian: 3.64		3.54	3.38	3.72		3.52
Patient-centered	IP Enterprise - HCAHPS Likelihood to Recommend	83.1	83.6	80.7	78.6	81.4		80.2
Patient-centered	ED - Likelihood to Recommend (PG)	75.7	78.2	73.9	78.7	76.5		76.5
Patient-centered	ECHMD - Likelihood to Recommend Care Provider (NPS)	73.2	75.7	76.2	76.0	76.4		76.1
Patient-centered	MCH - HCAHPS Likelihood to Recommend	84.1	84.6	82.9	78.2	83.4		81.4
Patient-centered	OAS - HCAHPS Likelihood to Recommend	84.7	86.4	83.5	86.1	86.1		85.2

Report updated 4/23/21

* data available up to FYTD 21 February only

** data available FYTD 21 January only, displays rolling 12 month data (December 2019 to January 2021)

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

LEAPFROG SCORES

El Camino Hospital (05-0308)
2500 Grant Road, Mountain View, CA 94040

My Score	My Letter Grade
3.3125	A

El Camino Hospital Los Gatos (05-0308)
815 Pollard Road, Los Gatos, CA 95032

My Score	My Letter Grade
3.1291	B

CMS Star Rating: Another 5 Star Score for El Camino

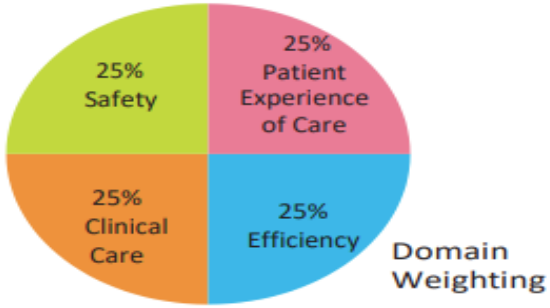
Overall Star Rating Results	Your Hospital's Results	National Average
Overall Star Rating [a]	***** (5 out of 5 stars)	*** (3 out of 5 stars)
Hospital Summary Score [b]	0.52	-0.05
Peer Grouping [c]	5 Measure Groups	--

Of the total 50 measures in the report, ECH's Measure results improved in many of them over the January 2020 report.

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.