El Camino Health

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

Monday, December 6, 2021 – 5:30pm
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

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

1-669-900-9128, MEETING CODE: 941 0003 6050#. 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 (11/01/2021) ***Information*** b. Report on Board Actions c. FY 22 Pacing Plan d. FY 22 Enterprise Quality Dashboard e. Quality Committee Follow-Up Tracking			
4.	**CHAIR'S REPORT**	Julie Kliger, Quality Committee Chair		**information 5:43 – 5:48**
5.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer		**discussion 5:48 – 5:53**
6.	**READMISSION DASHBOARD**	Mark Adams, MD, Chief Medical Officer		**discussion 5:53 – 6:13**
7.	**PSI REPORT**	Mark Adams, MD, Chief Medical Officer		**discussion 6:13-6:23**
8.	**REPORT ON MEDICAL STAFF PEER REVIEW PROCESS**	Mark Adams, MD, Chief Medical Officer		**information 6:23-6:38**
9.	**SEPSIS MORTALITY INDEX**	Mark Adams, MD, Chief Medical Officer		**discussion 6:38-6:53**
10.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**discussion 6:53-6:56**

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) 988-8483 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 6:56 – 6:57**
12.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 6:57-6:58**
13.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (11/01/2021) b. Quality Council Minutes (11/03/2021)	Julie Kliger, Quality Committee Chair		**motion required 6:58– 6:59**
14.	*Health and Safety Code Section 32155* **MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, CMO		**motion required 6:59-7:09**
15.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: **SERIOUS SAFETY EVENT/RED ALERT REPORT** (verbal report out)	Mark Adams, MD, CMO		**discussion 7:09-7:14**
16.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:14-7:15**
17.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		**information 7:15– 7:16**
18.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 7:16 – 7:21**
19.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:21 – 7:22pm**

Next Meeting: February 7, 2022, March 7, 2022, April 4, 2022, May 2, 2022, June 6, 2022

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, November 1, 2021
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

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

****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, Julie Kliger. A verbal roll call was taken. Ms. Simone joined at 5:35pm and Dr. Marfatia joined at 5:38pm. Dr. Sharma and Ms. Currie were not present during roll call. All other members were present at roll call and participated in-person or telephonically. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair 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	**Motion**: To approve the consent calendar. **Movant**: Kan **Second**: Ting **Ayes**: Kliger, Burn, Kan, Po, Somersille, Ting, Falwell **Noes**: None **Abstain**: None **Absent**: Marfatia, Sharma, Currie, Simon **Recused**: None Dr. Adams discussed a few items around the consent calendar: • Goal of C-Section of 2030 • Discharging patients on multiple anti-psychotics • MRI/Stroke Time	***Consent Calendar approved***
4. CHAIR'S REPORT	Chair Kliger asked that George Ting, MD to report on her behalf since she was absent at the last meeting. George Ting shared the Board reviewed the Financial Report. Net Operating Income was good considering Covid. Due to the stock market, Net income had a banner year. These results were audited by an Auditing firm and they reported back that everything was excellent.	

	In closed session, the Board reviewed the Executive Compensation more and approved the recommendations by the Executive Compensation Committee. One new item included was to purchase the property at 2660 Grant Rd. Additionally, in the last Board meeting Dan Woods, CEO provided an update on the Strategic Planning Process.	
5. PATIENT STORY	Cheryl Reinking, CNO presented a Press Ganey survey regarding a patient who was admitted to the hospital after dinner when food service was no longer available. In these situations, pre-made sandwiches are available to be given to patients. This patient was given a sandwich with apple slices. Unfortunately, the patient is allergic to apples. She did not eat the apples but a double check regarding food allergies was missed and it is important to note this allergy was listed in her chart. Going forward, there will be a sticker on the plate reminding the nurse to check the food allergy before giving it to the patient. Also, because of her after dinner admission, she was given a generic meal for breakfast versus having the opportunity to choose what she would like. Going forward, an alert will go out to the nurses to remind them to get the patients preference when it's a night admission.	
6. FY 2022 QUARTERLY DASHBOARD REVIEW	Dr. Adams and Dr. Reinking presented the FY22 Quarterly Dashboard and addressed the following items: • Catheter Associated Urinary Tract Infection metric • Patient Throughput metric • Sepsis Mortality Index Chair Kliger asked to add in the summary or overview section how these initiatives have affected the quarterly results when the Dashboard is reviewed again. Dr. Adams acknowledged and confirmed that can be done.	
7. EL CAMINO HEALTH MEDICAL NETWORK QUARTERLY REPORT	Ute Burness and Vince Manoogian presented the El Camino Health Medical Network Quarterly Report and reviewed the following: • 8 Quality Metrics – Overview • Quality Composite Metric Performance – FY22 Q1 • 2021 MIPS Performance YTD as of September 2021 Dr. Somersille requested to have additional information with how each protocol in place improved the metrics and by how much for the next meeting. Chair Kliger followed up by agreeing with Dr. Somersille's request stating the Committee would like a better understanding for each action item, what are the outcomes of those action items.	
8. PUBLIC COMMUNICATIONS	There was no public communication.	
9. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 6:53pm. **Movant**: Kan **Second**: Ting **Ayes**: Kliger, Burn, Kan, Marfatia, Somersille, Ting, Falwell, Simon **Noes**: None	***Adjourned to closed session at 6:53pm***

	Abstain: None **Absent**: Po, Sharma, Currie **Recused**: None	
10. AGENDA ITEM 17: RECONVENE OPEN SESSION/REPORT OUT	Open session was reconvened at 7:14 pm. Agenda items 11-57 were covered in the closed session. During the closed session, the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (10/04/2021), Quality Council Minutes (10/06/2021), and Medical Staff Credentialing and Privileges Report.	
11. AGENDA ITEM 18: CLOSING WRAP UP	Chair Kliger reminder the Committee that the next meeting is December 6th and the Committee can attend in-person.	
12. AGENDA ITEM 19: ADJOURNMENT	**Motion**: To adjourn at 7:17pm **Movant**: Burn **Second**: Falwell **Ayes**: Kliger, Burn, Kan, Marfatia, Somersille, Ting, Falwell, Simon **Noes**: None **Abstain**: None **Absent**: Po, Sharma, Currie **Recused**: None	***Adjourned at 7:17pm***

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Julie Kliger, MPA, BSN
Chair, Quality Committee

Prepared by: Nicole Hartley, Executive Assistant II

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee
From: Stephanie Iljin, Supervisor Executive Administrative Services
Date: December 06, 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 once and District Board has not met. In addition, since the Board has delegated specific authority to the Executive Compensation Committee, the Compliance and Audit Committee, and the Finance Committee, those approvals are also noted in this report.

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	November 10, 2021	- Minutes of the Open & Closed Session of the Hospital Board Meeting (10/13/2021) - Credentialing and Privileges Report - Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations - Policy Revisions - FY 21 Period 2 Financials - Medical Staff Report
ECHD Board	- N/A	
Executive Compensation Committee	November 04, 2021	- Minutes of the Open & Closed Session of the ECC Meeting (9/28/2021) - Minutes of the Open & Closed Session of the ECC Meeting (10/20/2021) - Recommend to Appoint Executive Compensation Committee Members - Executive Relocation Program - FY21 CEO Performance Review Process and FY22 Recommendations - Letter of Rebuttable Presumption of Reasonableness - Individual Executive Goals Update

Report on Board Actions
December 6, 2021

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
Compliance and Audit Committee	November 18, 2021	- Minutes of the Open & Closed Session of the CAC Meeting (09/30/2021) - KPI Scorecard and Trends - Activity Log September 2021 - Activity Log October 2021 - Internal Audit Work Plan - Internal Audit Follow Up Table - Committee Pacing Plan
Finance Committee	November 22, 2021	- Minutes of the Open & Closed Session of the FC Meeting (09/27/2021) - FY 22 Period 3 Financials - FY 22 Period 4 Financial Report & Capital Expenditure Update - Intent to Reimburse: Resolution - LG Critical Care Unit Emergency Department and Inpatient Coverage On-Call Panel Renewal - Enterprise Radiology Professional Services Renewal Agreement - Mountain View OBGYN Call Panel Renewal

List of Attachments: None.

Suggested Committee Discussion Questions: None.

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

Revised 11/18/2021 **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** **Additional Agenda Items:** 1. Health Care Equity 2. ~~Culture of Safety~~ (Oct 4) 3. Patient Perspective 4. Likely to Recommend 5. ~~Sepsis Mortality Goal/Target~~ (Dec 6) 6. Quality Metric Trends 7. OPPE 8. Systemness 9. Nurse Sensitive Indicators	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 7. Q4 FY21 Quarterly Quality and Safety Review 8. Quarterly Board Dashboard Review 9. 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: 6. Annual Patient Safety Report 7. 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. FY 21 & FY 22 Quality Dashboard Results 8. Culture of Safety Survey 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. FY 22 Quarterly Board Dashboard Review 10. EL Camino Health Medical Network Report 11. Medical Staff Office Audit 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. Report on Medical Staff Peer Review Process 10. Sepsis Mortality Goal/Target Discussion

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

Revised 11/18/2021 **FY22 Pacing Plan**

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 Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Catherine Carson, MPA, BSN, CPHQ, Sr. Director Quality
Date: December 06, 2021
Subject: FY22 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 2021 metrics monthly with trends over time and compared to the actual results from FY2020 and the FY 2021 goals.
- **B.** Annotation is provided to explain each metric.

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

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

4. Assessment:

- **A.** Readmission Index @ 1.07 with 231 readmissions
- **B.** 6 SSEs for September 2021: 4 events were categorized as SSE5 - medication event (1), incorrect treatment(1) , delay in treatment(2) and 2 events categorized as SSE4 – both related to HAIs
- **C.** Precursor Medication Safety Events: 16 - Top 4 trends include – pump misprogramming(3), incorrect dose (3) and omitted dose (4)
- **D.** Mortality Index decreased to 0.84 with 37 deaths
- **E.** HCAHPS Likelihood to Recommend for inpatient units increased to 81.9
- **F.** ED LTR improved to 73.9
- **G.** ECH MD Likelihood to Recommend improved to 76.8
- **H.** One Surgical Site Infections in MV
- **I.** Sepsis mortality Index increased to 1.05
- **J.** PC-01 w/1 exceptional case needing delivery to have a cancer treatment
- **K.** PC-02, Cesarean Sections decreased across the enterprise
- **L.** Patient Throughput minutes increased.

5. Other Reviews: None

6. Outcomes:

Suggested Committee Discussion Questions: None

FY 22 Enterprise Quality, Safety, and Experience Dashboard
December 06, 2021

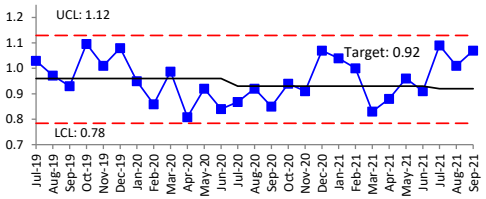
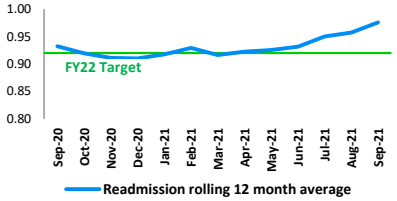
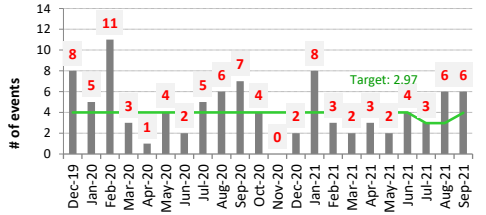
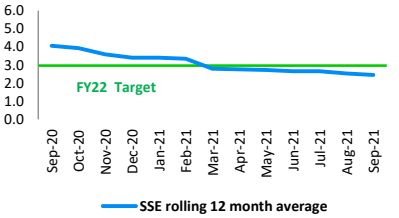
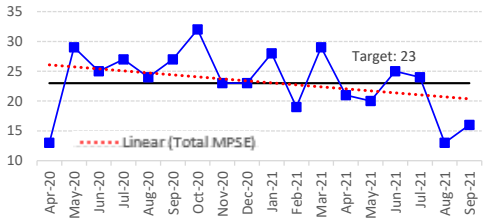
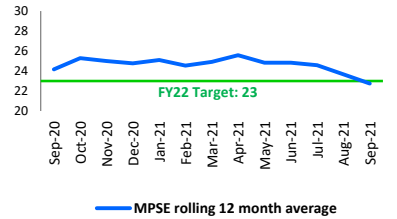
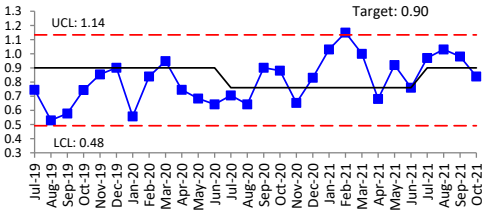
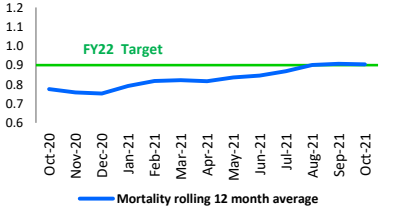
List of Attachments: FY 2022 Enterprise Quality, Safety, and Experience Dashboard, September & October data

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

October 2021 (unless otherwise specified)

Month to Board Quality Committee:
December, 2021

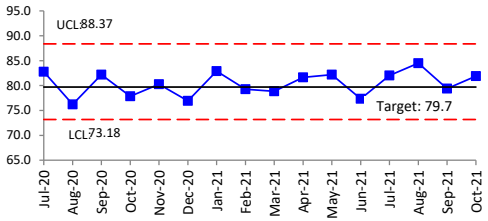
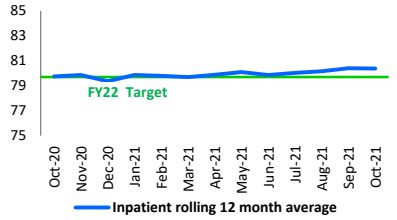
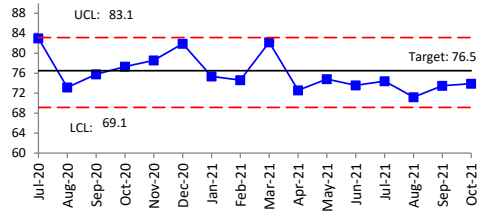
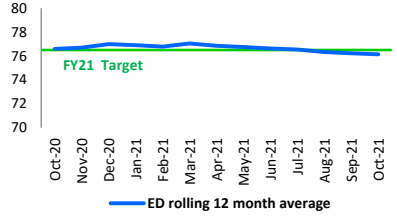
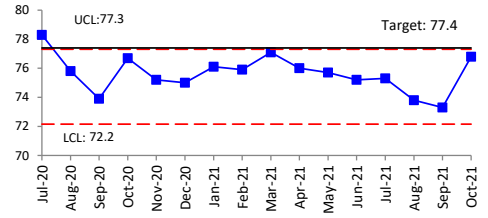
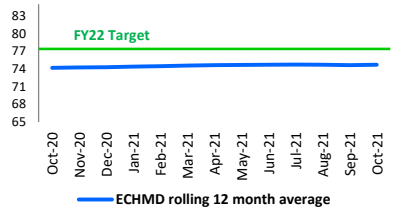
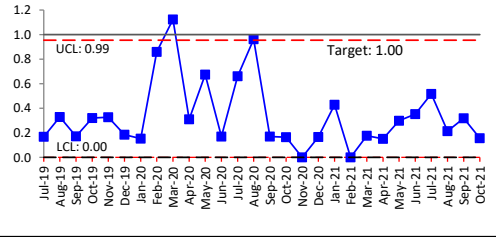
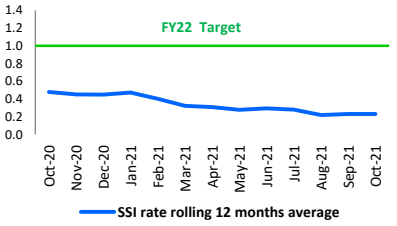
		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Standard Risk Calculation Mode*** ***Latest data month: September 2021*	1.07 (9.01%/8.42%)	1.06 (8.82%/8.36%)	0.93	0.92		
2	*Organizational Goal **Serious Safety Event Rate (SSER) per month** # of events/ FYTD rolling 12 month per 10,000 Acute Adjusted Patient Days *Rate* ***Latest data month: September 2021*	6	2.45 (43/175321)	3.13 (Dec 2019 - Jun 2021)	2.97		
3	**Actual # of Medication Precursor Safety Events (MPSE) per month/** FYTD rolling 12 month average ***Latest data month: September 2021*	16	22.8/ mo. (12 month rolling average)	320 (25/month) *(April 2020 to April 2021)*	304 (23/month) *(5% reduction from baseline)*		
4	* Strategic Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: October 2021*	0.84 (1.78%/2.12%)	0.95 (1.65%/1.75%)	0.86	0.90		

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

October 2021 (unless otherwise specified)

Month to Board Quality Committee:
December, 2021

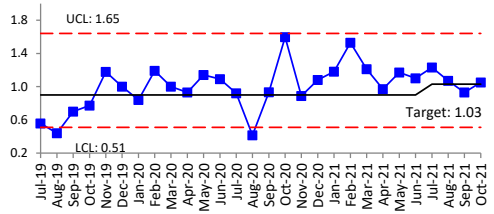
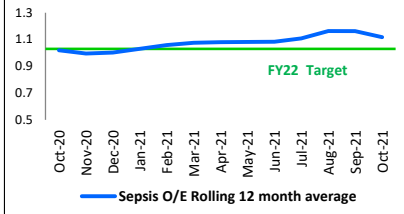
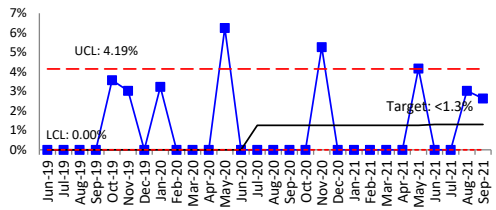
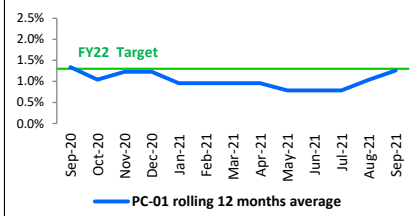
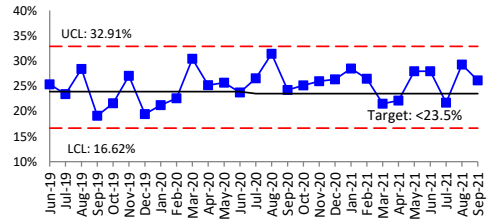
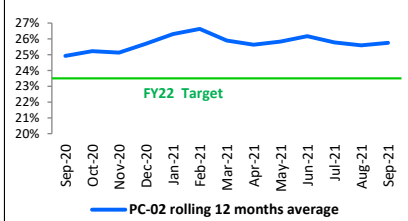
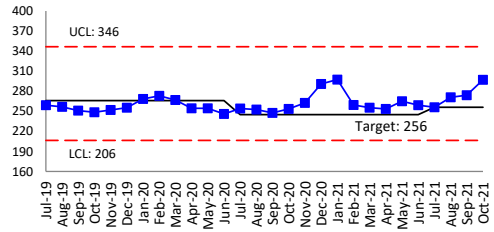
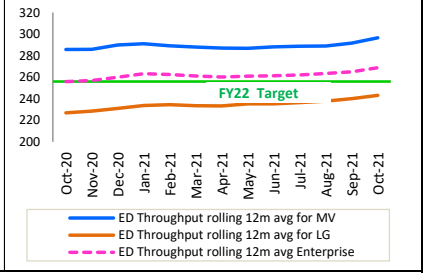
		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Month Average
		Latest month	FYTD				
5	*Organizational Goal **IP Units - HCAHPS Likelihood to Recommend -** *exec MBU,* **Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: October 2021*	81.9	82.0	79.6 (n=1983)	79.7		
6	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: October 2021*	73.9	73.3	76.1 (2347)	76.5		
7	* Organizational Goal **ECH MD : Likelihood to Recommend Care Provider** (SVMD only) **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Adjusted** *Latest data month: October 2021*	76.8	74.7	76.0 (n=15,330)	77.4		
8	**Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Latest data month: October 2021*	0.16 (1/645)	0.30 (7/2319)	0.30 (21/7016)	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

October 2021 (unless otherwise specified)

Month to Board Quality Committee:
December, 2021

		FY22 Performance		Baseline FY21 Actual	FY 22 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: October 2021*	1.05 (10.85%/10.37%)	1.06 (10.85%/10.19%)	1.08 (12.86%/11.87%)	1.03		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) ***Latest data month: September 2021*	MV: 0.0% (0/31) LG: 14.3% (1/7) ENT: 2.6% (1/38)	MV: 1.1% (1/93) LG: 5.9% (1/17) ENT: 1.8% (2/110)	MV: 0.41% (1/244) LG: 1.32% (1/76) ENT: 0.63% (2/320)	1.3%		
11	**PC-02: Cesarean Birth** (lower is better) ***Latest data month: September 2021*	MV: 26.8% (44/164) LG: 23.1% (9/39) ENT: 26.1% (53/203)	MV: 26.7% 120/450) LG: 22.4% (26/116) ENT: 25.8% (146/566)	MV: 27.58% (422/1530) LG: 20.69% (72/348) ENT: 26.30% (494/1878)	23.5%		
12	***Strategic Goal** **Patient Throughput- Median Time from Arrival to ED Departure** *(excludes psych patients, patients expired in the ED, Newborns, and transfer between sites)* *Latest data month: October 2021*	MV: 330 min LG: 264 min Ent: 297 min	MV: 299 min LG: 246 min Ent: 273 min	MV: 288 min LG: 239 min Ent: 264 min	MV: 263 min LG: 227 min Ent: 256 min		

** Readmission, SSE, MPSE, PC-01 and PC-02 data are available up to September only

Report updated: 10/29/21

Quality Committee Follow up Item Tracking Sheet (12/06/2021)

#	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

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: December 6, 2021
Subject: Patient Experience Feedback from Patient Letter

Purpose: To provide the Committee with written patient feedback that is received from a patient.

Summary:

1. Situation: In honor of the holiday season, a positive letter was included this month highlighting the many processes and staff that are involved in providing service to a patient scheduled for surgery.

2. Authority: To provide insight into one patient's experience who noticed every step of her preparation for a procedure and nearly everyone she came in contact with which led to a positive experience due staff listening, explaining, and demonstrating compassion.

3. Background: This patient was scheduled for surgery at El Camino Los Gatos and subsequently had a procedure there and outlined her experience in the letter.

4. Assessment: This feedback is very detailed and generous. This provides as a method to provide feedback directly to the staff who are contributing to positive patient experiences along the continuum of care. It promotes a sense of pride and meaning when staff hear what a difference their individual care made in the patient's experience.

5. Other Reviews: None

6. Outcomes: The leaders shared this card with each staff member involved and it was read at the enterprise huddle and shared with community relations in case there is a broader use of this patient's voice.

7. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. How do you share positive feedback with each staff member?

2. How do you share such positive feedback across the enterprise?

[redacted]

[redacted]

November 8, 2021

Meriam Signo

Director of Nursing Services

El Camino Hospital

815 Pollard Road, Los Gatos, CA 95032

Dear Meriam Signo:

From the bottom of my heart, I give you my gratitude for having an exemplary nursing staff. Before I had my surgery, your staff called me to make certain that I make an appointment to have the PSR COVID test 3 days prior to surgery. The instructions were clear regarding exactly where I was supposed to go. The nurse made certain that I knew exactly how the test will be conducted and what I am to expect. She, also, gave me my pre-op kit and instructions. Next, she directed me to the main entrance to go to Patient Services. At Patient Services, the clerk was professional and clearly explained the forms I needed to sign. She even walked me to the Laboratory. Joseph was professional and walked me through the process of collecting bloodwork and urine test. I was also given clear instructions on where to park and where to go for outpatient surgery. The day before surgery, I received a call to walk me through the process of preparing for surgery.

The day of the surgery went very well. I especially highly commend Kari Nagamine for preparing me for surgery and asking all of the right questions and walking me through the process. The anesthesiologist also talked with me about my concerns (I had a prior surgery by a different doctor and hospital and had a bad experience.) The staff and doctors reassured me that things will go very well this time around. I woke up within an hour after surgery. The bedside nurses walked me through the process of recovering from surgery and made certain that my doctor's orders were followed through. From this team, I highly commend Joji Bacani for being thorough in going through the prior nurses' notes and making certain that I'm preparing for the night at the hospital. The next morning, I highly commend Manuel Amaya for his professionalism in carefully removing the IV, as I am fearful of needles.

Should I have any colleagues, family members or friends who need outpatient surgery, I will be certain to refer them to El Camino Health of Los Gatos. Thank you for all of your support. And, I wish you and your staff only the very best this holiday season. Take care.

[redacted]

[redacted]

[redacted]

El Camino Health

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EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Catherine Carson, Sr. Director Quality
Date: December 6, 2021
Subject: Q1 FY2022, 30 day All Cause, Unplanned Readmission Dashboard

Purpose: To provide comparison observed over expected (O/E) data on the 7 diagnoses measured as part of the HRRP Readmission Penalty program. Readmissions Index all payor/all cause for FY 2017, FY 2018, FY 2019, FY 2020, FY2021 and through end of Q1 2022. HRRP penalizes hospitals up to 3% of their inpatient Medicare revenue based for having worse-than-expected readmissions rates of ***any*** of the 6 conditions listed. At risk are those diagnoses with O/E above 1.0.

Summary:

1. Situation: ECH Organizational goal: Readmission Index, and hospitals incur as penalty under ACA of up to 3% of DRG payments for Readmission rates that are above CMS calculated expected for 7 diagnosis and procedures. Readmission Teams are focusing on readmissions in each category. A penalty is assigned to the hospital if any of the 7 categories are above the Expected rate.

2. Authority: Quality Committee of the Board is responsible for oversight of quality & safety.

3. Background: Readmission rates provided the 7 diagnosis groups for FY2017, FY2018, FY2019, FY2020, FY2021 and Q1 FY2022

4. Assessment: This report for the 7 diagnosis groups the same readmission index at 0.93 as the overall Readmission Index for the ECH FY2021 Organizational goal. The current O/E for Q1 FY 22 of 1.03 for these 7 diagnosis groups also reflects the increase in the overall readmission index that we are seeing. The O/E ratio is greater than 1.0 for 4 of the 7 diagnoses: AMI, Heart Failure, Pneumonia, and Total Hip/Total Knee Arthroplasty.

5. Other Reviews:

6. Outcomes:

List of Attachments:

1. Q1 FY2022 30 day All Cause, Unplanned Readmission Dashboard

Suggested Committee Discussion Questions:

1. None

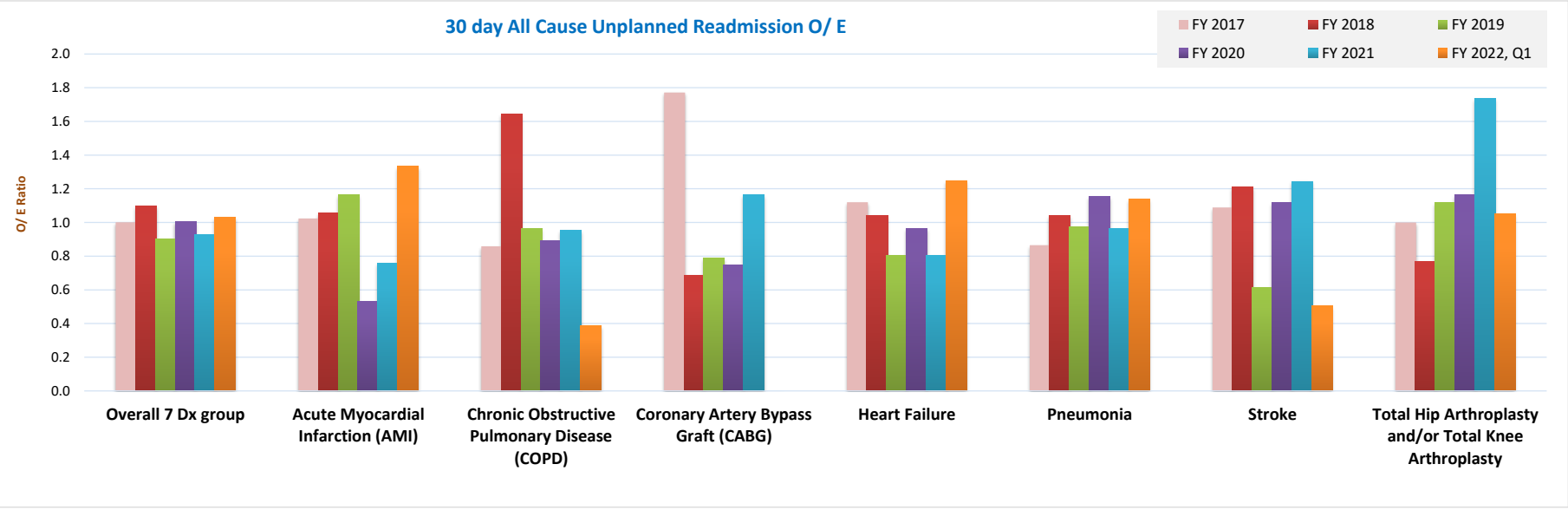
El Camino Health

FY 2022 end of Q1 - 30 Day All-Cause Readmission Dashboard - ACA Dx.

Premier Risk Adjusted, All Payer, All Cause, Unplanned Readmits

Patient Type: Inpatient

	FY 2017			FY 2018			FY 2019			FY 2020			FY 2021			FY 2022, Q1		
	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio
Overall 7 Dx group	**9.08%**	**9.08%**	**1.00**	**10.02%**	**9.11%**	**1.10**	**8.95%**	**9.92%**	**0.90**	**10.64%**	**10.60%**	**1.00**	**10.82%**	**11.69%**	**0.93**	**11.75%**	**11.41%**	**1.03**
Acute Myocardial Infarction (AMI)	7.69%	7.51%	1.02	7.72%	7.30%	1.06	8.75%	7.53%	1.16	3.92%	7.36%	0.53	6.51%	8.58%	0.76	9.59%	7.20%	1.33
Chronic Obstructive Pulmonary Disease (COPD)	14.14%	16.48%	0.86	26.97%	16.41%	1.64	14.88%	15.40%	0.97	14.97%	16.75%	0.89	17.43%	18.29%	0.95	6.06%	15.71%	0.39
Coronary Artery Bypass Graft (CABG)	11.24%	6.34%	1.77	4.63%	6.76%	0.69	5.38%	6.81%	0.79	5.33%	7.15%	0.75	7.50%	6.43%	1.17	0.00%	4.10%	0.00
Heart Failure	17.79%	15.89%	1.12	16.17%	15.52%	1.04	13.39%	16.67%	0.80	16.44%	17.03%	0.97	13.17%	16.36%	0.80	20.00%	16.04%	1.25
Pneumonia	10.31%	11.92%	0.87	12.82%	12.30%	1.04	12.50%	12.84%	0.97	14.41%	12.51%	1.15	13.08%	13.54%	0.97	15.96%	14.02%	1.14
Stroke	7.17%	6.58%	1.09	8.20%	6.77%	1.21	4.56%	7.41%	0.62	8.15%	7.29%	1.12	8.98%	7.22%	1.24	4.17%	8.28%	0.50
Total Hip Arthroplasty and/or Total Knee Arthroplasty	2.06%	2.08%	1.00	1.63%	1.99%	0.77	2.54%	2.27%	1.12	2.83%	2.42%	1.17	4.40%	2.53%	1.73	2.94%	2.79%	1.05



Report updated: 11/16/21

Source: Premier Quality Advisor, Standard CareScience Risk Calculation, All-Cause Hospital-Wide 30-Day Readmissions

El Camino Health

CONFIDENTIAL
EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Catherine Carson, Sr. Director Quality
Date: December 6, 2021
Subject: Patient Safety Indicator (PSI) Scores FY22 Q1 compared to Q1-Q4 FY21

Purpose: To provide an update on the AHRQ Patient Safety Indicators for Q1 FY22.

Summary:

1. Situation: The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events for all patients following surgeries, procedures, and childbirth. These events are amenable to changes in the health care system or provider. The PSIs were developed after a comprehensive literature review, analysis of ICD-10-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.

2. Authority: Quality Committee of the Board is responsible for oversight of quality & safety.

3. Background: The PSIs can be used to help hospitals identify potential adverse events that might need further study; provide the opportunity to assess the incidence of adverse events and in- hospital complications using administrative data found in the typical discharge record; include indicators for complications occurring in hospital that may represent patient safety events; and, indicators also have area level analogs designed to detect patient safety events on a regional level.

4. Assessment: Each of the PSI are first reviewed and validated by the CDI manager and Coding manager, and are then sent through the Medical Staff's Peer review process for trending by physician. In this report PSI rates that are better than the Premier Mean are highlighted in green.

- **A.** PSI-03 Pressure Ulcer – 1 in Q1; A COVID-19 pt. in MV-CCU developed penile corona from proning pressure
- **B.** PSI-09 Perioperative hemorrhage or hematoma – 3 occurrences, reduced from 5 in the last report
- **C.** PSI-10 Postoperative Acute Kidney Injury Requiring Dialysis – 1 occurrence.
- **D.** PSI-17 Birth Trauma Injury to Neonate – 6 occurrences
- **E.** PSI-18 and PSI-19 OB Vaginal trauma with & without instrument – both begin addressed by Maternal Child Health Medical Leadership with case review and education on documentation of injury

5. Other Reviews:

6. Outcomes:

List of Attachments:

1. Patient Safety Indicator (PSI) Scores Q1 FY22.

Suggested Committee Discussion Questions: None

Patient Safety Indicator Report (AHRQ) All Patients FY21 compared to FY22 (Q1)

Rate Measures

Patient Safety Indicator		Numerator (FY22 Q1)	Denominator (FY22 Q1)	Rate/1000 (FY22 Q1)	Premier Mean* (FY22 Q1)	Numerator (FY 21,Q1-4)	Denominator (FY 21,Q1-4)	Rate/1000 (FY 21,Q1-4)	Premier Mean* (FY 21,Q1-4)
PSI-02	Death in Low Mortality DRGs	0	314	0.00	1.18	0	1,275	0.00	1.18
PSI-03	Pressure Ulcer	1	2,138	0.47	0.44	7	8,431	0.83	0.44
PSI-04	Death in Surgical Pts w Treatable Complications	0	35	0.00	121.71	11	108	101.85	121.71
PSI-06	Iatrogenic Pneumothorax	0	3,423	0.00	0.12	3	13,134	0.23	0.12
PSI-07	Central Venous Catheter-Related Blood Stream Infection	0	3,095	0.00	0.10	0	11,156	0.00	0.10
PSI-08	In Hospital Fall with Hip Fracture	0	2,707	0.00	0.11	0	10,538	0.00	0.11
PSI-09	Perioperative Hemorrhage or Hematoma	3	908	3.30	1.68	7	3,675	1.90	1.68
PSI-10	Postoperative Acute Kidney Injury Requiring Dialysis	1	469	2.13	0.76	0	2,022	0.00	0.76
PSI-11	Postop Respiratory Failure	1	365	2.74	5.20	4	1,605	2.49	5.20
PSI-12	Perioperative PE or DVT	3	964	3.11	2.48	8	3,905	2.05	2.48
PSI-13	Postop Sepsis	0	464	0.00	4.21	6	2,010	2.99	4.21
PSI-14	Postop Wound Dehiscence	0	312	0.00	0.79	0	1,305	0.00	0.79
PSI-15	Unrecognized Abdominopelvic Accidental Puncture or Laceration	0	819	0.00	0.71	2	3,408	0.59	0.71
PSI-17	Birth Trauma Injury to Neonate	6	1,313	4.57	3.78	15	4,199	3.57	3.78
PSI-18	OB Trauma Vaginal Delivery with Instrument	8	70	114.29	103.67	48	207	231.88	103.67
PSI-19	OB Trauma Vaginal Delivery without Instrument	22	848	25.94	17.55	102	2,765	36.89	17.55

Count Measures

Patient Safety Indicator		Cases (FY22-Q1)	Premier Mean Cases*	Cases (FY21,Q1-4)	Premier Mean Cases*
PSI-05	Retained Surgical Item or Unretrieved Device Fragment	0	0.07	0	0.07

Green=better than Premier comparative mean

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Board Quality Committee
From: Mark Adams, MD, CMO
Date: December 6, 2021
Subject: Medical Staff Peer Review Process

Purpose:

Present the current medical staff approach to peer review

Recommendation:

No motion required

Authority:

Peer review is an essential function of the organized medical staff but oversight of this function is a Board responsibility.

Situation:

The Quality Committee requested an overview of the peer review process.

Background:

Professional physician peer review is an expected and required function of the organized medical staff (OMS). Traditionally, this was accomplished by specialty specific departments which often created inconsistent results as this was then limited to smaller groups of physicians often in competition with each other making objective determinations difficult and unreproducible. Based on recommendations from experts in this area such as The Greeley Company and Horty Springer Health Law, many organizations have moved to a more modern approach to peer review which is characterized by the term Multi-Specialty Peer Review. This involves the creation of an enterprise wide peer review process that is concentrated in a single body which is made up of dedicated, specifically trained physicians that are separate from departments, elected leaders, and medical politics. Peer review triggers are then developed to assure that all appropriate cases are reviewed. The El Camino Health medical staff engaged an outside consultant two years ago to assist in the development of a Multi-Specialty Peer Review process. The consultant helped the medical staff revise the bylaws to adopt this approach. Bylaw changes were then made at that time and these were approved by the medical staff at large prior to the onset of the pandemic.

Assessment:

"**Peer Review**" refers to the good faith activities utilized by the organized **medical staff** to conduct patient care **review** for the purpose of analyzing and evaluation the quality and appropriateness of care provided to patients. The basic underlying principles include:

a. Fairness
b. Credibility
c. Consistency

d. Efficiency

The transition to this Multi-Specialty Peer Review approach has proceeded better than expected with the newly formed committee working at a very high level as confirmed by the recent internal audit presented to the Board Compliance Committee.

List of Attachments:

1. Power Point explaining peer review
2. Diagram of peer review work flow

El Camino Health

Peer Review

Quality Committee

Dr. Mark Adams, CMO
December 6, 2021

Peer Review Agenda

- What is Peer Review?
- How has the Peer Review process changed?
- What are the underlying principles?
- What factors must be considered?
- How is the El Camino medical staff performing in this new approach?

What is Peer Review

"**Peer Review**" refers to the good faith activities utilized by the organized **medical staff** to conduct patient care **review** for the purpose of analyzing and evaluation the quality and appropriateness of care provided to patients.

This is one of the most essential functions of the organized medical staff

What is Peer Review?
It may depend on the perspective!

- Physician- a method of delivering me my performance information evaluated by my peers so that I may improve my clinical care- Excellence standard

- Medical Staff leadership- a method of delivering performance information so that I may evaluate individual performance for acceptability- Competence standard

What has Changed?

- Historically, physician peer review systems were
  - Dependent on case review
  - Conducted by specialty
  - Inconsistent and inherently biased

- Contemporary peer review models are
  - Moving from a dependence on case review to utilization of aggregate data
  - Conducted in forums with multi-specialty participation

Basic Underlying Principles

- Fairness
- Credibility
- Consistency
- Efficiency

Fairness

- Limit bias (individual or group) to the extent possible
- Conflict of interest- Absolute vs. Relative
- Decide measurement factors proactively
- Maintain process transparency

Credibility

- Its all about the data
  - Attribution
  - My patients are sicker
  - The p isn’t less than 0.05
- The enemy of good should not be perfect
- Data sources should be as good as possible

Consistency

- Inter-rater reliability
  - Case review
  - Aggregate data

- Collect equivalent data for equivalent practitioners

Efficiency

- Make best use of physician time as possible
  - Focused reviews
  - Committee time has bias towards action
  - Separate rating/evaluation function from action responsibility
- Support staff has marked limitations as well- make good use of limited resources
- Automate to the extent possible

Peer Review System Design Factors

- Must apply the Basic Underlying Principles
  - Define who is a peer
  - Define what performance data is to be collected- Indicators
  - Define how that data is transformed into useful information
  - Define the process of performance reporting and management
  - Define a viable peer review structure
  - Define a viable case review process

What makes up a good Case Review Process?

1. Case Gathering
2. Case Screening
3. Initial Review
4. Initial Committee Discussion
5. Involved Practitioner Input
6. Final Committee Decision
7. Communication of Decision
8. Improvement plan

Multispecialty Peer Review

- The medical staff has moved from the old school system to this new approach
- While some specialties may continue to perform baseline peer review, all final adjudication of peer review findings are now the responsibility of this enterprise Practitioner Excellence Committee

Multispecialty Peer Review

- Indicators that trigger peer review have been identified
- Committee membership is based on expertise and commitment
- Trending and tracking are emphasized over incident reporting to reduce bias

Multispecialty Peer Review

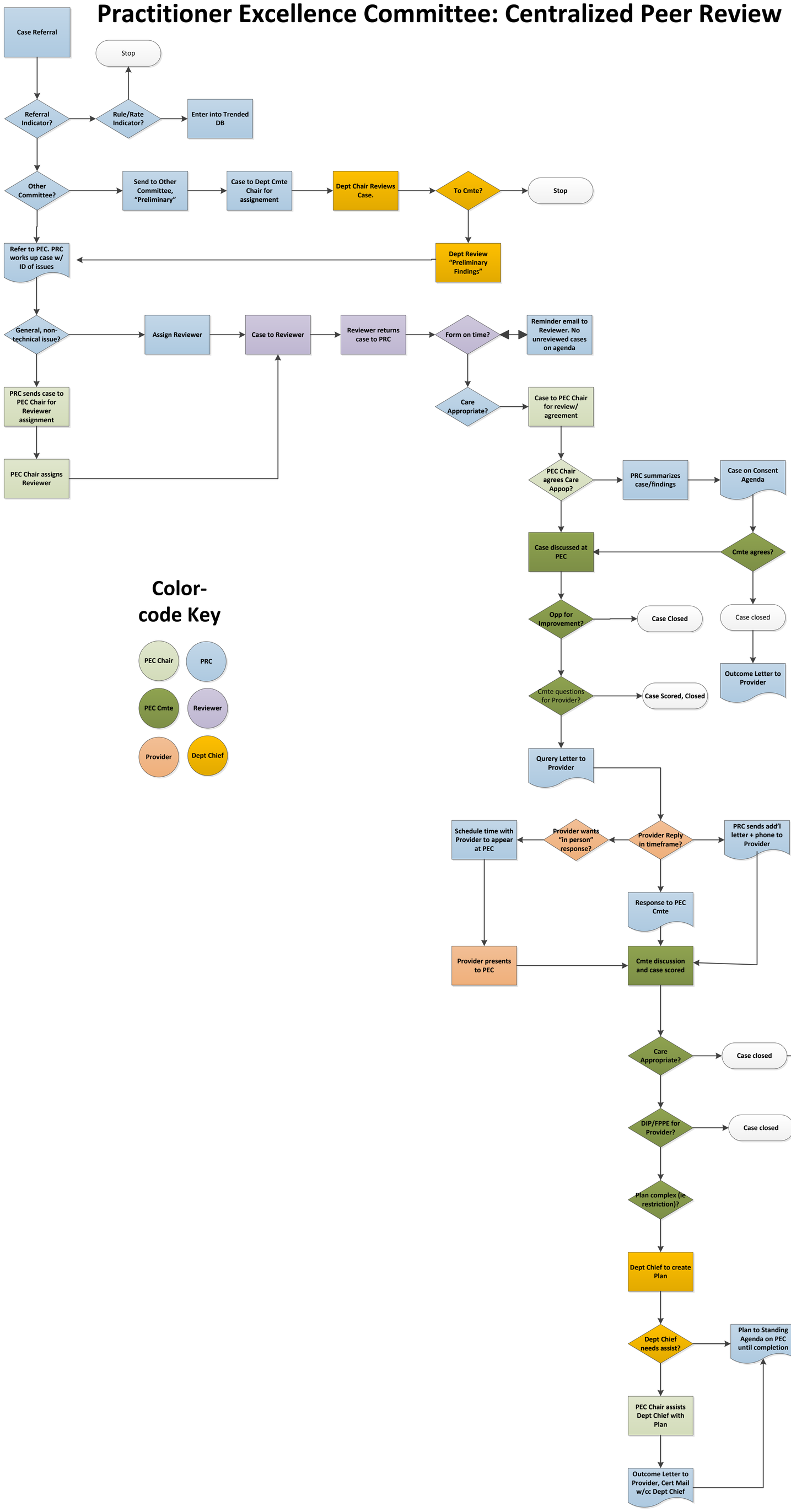
Possible determinations by the committee:

- Care meets standards
- Opportunity for Improvement Minor
- Opportunity for Improvement Major
- Exceptional Care
- System Issue identified

Recent Internal Audit Results

- The peer review process and documentation met the regulatory compliance for periodic evaluations of members. To meet survey expectations a new *Case Rating Form* was developed and used across all departments to evaluate practitioners for the peer review. The case rating form evaluated practitioners across same criteria/standards and provided consistency in the evaluation.

Practitioner Excellence Committee: Centralized Peer Review



Color-code Key

PEC Chair

PRC

PEC Cmte

Reviewer

Provider

Dept Chief

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Board Quality Committee
From: Mark Adams, MD, CMO
Date: December 6, 2021
Subject: Sepsis Mortality Index

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

Recommendation: No motion required

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

Situation: The Sepsis Mortality Index has increased over the past fiscal year which is a nationally recognized shift even among the very top health system performers. The FY22 Sepsis Mortality Index target has been adjusted accordingly.

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

Assessment: Based on FY21 data analysis and clinician feedback here is a summary of the findings for current state:

- Overall higher sepsis bundle compliance in the survival group, particularly interventions shown to benefit outcomes (time to antimicrobial therapy, fluid resuscitation and prevention of progression to shock).
- Prolonged hypotension has been a common theme in many case reviews, timeliness to vasopressor initiation was lacking.
- Higher percentage of DNR (60% of mortality cases) on admission and advanced age & co-morbid conditions (oncology patients).
- Patients are presenting to the ED in late state of sepsis/disease process. Community fears around coming to the hospital in the midst of pandemic have decreased the opportunities to benefit from early intervention.
- Learning curve for treating severe COVID: lower use of antibiotics, also clinicians hesitant to fluid resuscitate patients with COVID and shock due to high potential to progress to ARDS. More research is forthcoming on how sepsis bundle should be modified for this population.
- Less family presence during pandemic visitor restrictions have decreased opportunities to have end of life discussions and/or transitions to hospice.
- Significant decrease in GIP (general inpatient hospice) care transitions.

The FY22 sepsis mortality index improvement plan has two major components which are improve clinical care and improve conversion of terminal sepsis cases to GIP:

Improve Clinical Care

- Increase 3 hr. bundle compliance – especially ABX within 1 hr., Fluid bolus, and MAP compliance
  - Encourage provider attendance at 12/14 Townsend CME re: ECH reluctance re: fluid resuscitation
- Increase overall SEP-1 bundle compliance – 3hr + 6hr bundle
  - Provide provider level data on bundle compliance by specialty and for OPPE
- Improve Order set usage
  - Data on order set use by provider to Medicine Exec. Meeting
  - Revised data for ED with new sepsis alert process and workflow
- Reduce wait time to transfer into CCU – from the ED and from the Floor
  - More rapid acceptance of sepsis patients by intensivists
- Reduce hours of hypotension – improve more rapid use of vasopressors
  - Vasopressors can be initiated with peripheral line

Improve Conversion of Terminal Sepsis cases to GIP

- Sepsis Navigator position to focus on improved communication w/patient, family & palliative care
- Encourage providers to document existing diagnosis on patient problem list so these diagnosis can be coded in this encounter even if not treated (history of cancer though admission is for sepsis)
- Provide education to Palliative care team regarding 6 month survivability of sepsis patients post hospitalization
- Encourage Palliative care team to approach all sepsis patients and family members who have DNR orders for conversations on end of life plans

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

List of Attachments:

1. Sepsis Mortality Index Analysis
2. Sepsis Dashboard
3. Sepsis Mortality A3

El Camino Health

Sepsis Mortality Index Analysis

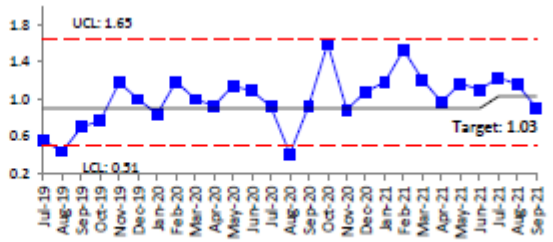
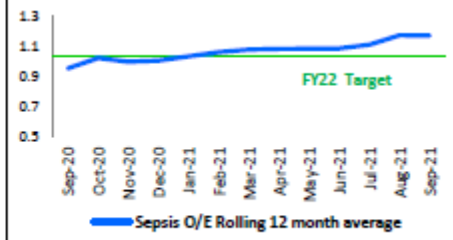
Prepared by Catherine Carson, Sr. Director Quality,
Jessica Harkey, Manager, Sepsis Quality and
Yuliya Koskov, Quality Data Analyst- Sepsis Program
November 23, 2021

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

September 2021 (unless otherwise specified)

Month to Board Quality Committee: November, 2021

		FY22 Performance		Baseline FY21 Actual	FY 22 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: September 2021	0.91 (9.77%/10.70%)	1.06 (10.88%/10.24%)	1.08 (12.86%/11.87%)	1.03		

ECH Sepsis Program

El Camino Health
Quality, Safety and Risk

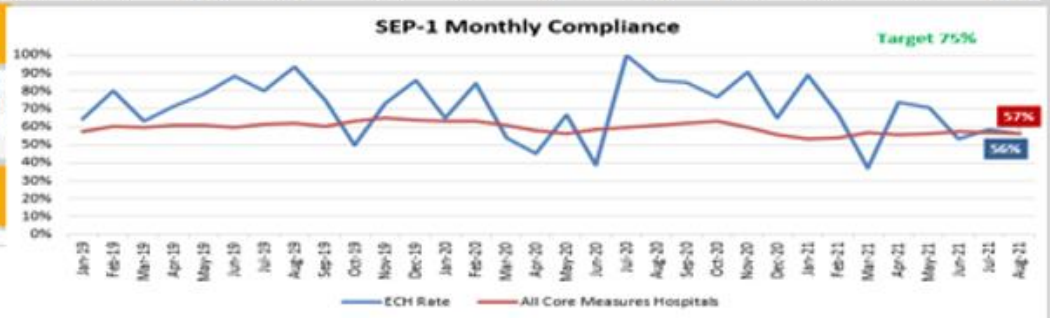
ECH Compliance Rate September 2021	ALOS September 2021	Top Admitting Units September 2021	
44% (n=27/61)	6.41	LG L06 INTENSIVE CARE UNIT	6
		MV 2C MEDICAL	9
		MV 3AC CCU	12
		MV 3AP PCU	10

Sepsis Bundle Metrics (Rolling 12 Months)

	September 2021	August 2021	July 2021	June 2021	May 2021	April 2021	March 2021	February 2021	January 2021	December 2020	November 2020	October 2020
Lactate Drawn w/in 1 hr of TOP-Target 75%	89%	95%	92%	94%	100%	88%	97%	98%	91%	93%	95%	93%
Abx given within 1 hour of TOP- Target 75%	67%	84%	73%	66%	77%	80%	77%	84%	70%	79%	75%	76%
Blood cultures drawn prior to abx admin-Target 75%	87%	83%	88%	83%	83%	90%	93%	90%	87%	90%	91%	88%
Appropriate selection based on suspected source (1)	97%	100%	98%	95%	98%	97%	93%	97%	98%	97%	97%	98%
Was 30mL/kg cryst Fluid Given w/in 3 hours (2) - Target 90%	48%	78%	64%	76%	71%	70%	77%	56%	53%	81%	70%	66%
Repeat Lacate Done w/in 6 hrs (3) - Target 90%	93%	90%	96%	89%	100%	100%	98%	96%	93%	94%	90%	93%
Vasopressor administered for shock (4)	38%	67%	54%	67%	88%	70%	88%	50%	62%	50%	71%	33%
Norepi first choice (5)	75%	100%	100%	100%	100%	86%	93%	83%	88%	100%	88%	100%
MAP>=65 at 6 hours from TOP-Target 90%	82%	95%	85%	94%	90%	85%	87%	90%	85%	80%	81%	75%
Shock Re-assessment (6) - Target 75%	85%	95%	74%	69%	89%	84%	88%	85%	62%	89%	78%	72%
Observed mortality(not risk adjusted)	12%	8%	8%	16%	7%	14%	10%	10%	13%	25%	20%	15%
Sepsis Alert Rate	17%	9%	6%	10%	3%	12%	12%	11%	13%	3%	14%	14%
ECH Bundle Comp Rate	44%	63%	50%	53%	55%	65%	60%	53%	42%	59%	45%	42%

#1 Infection September 2021		Top D/C Locations September 2021	
Lungs	15	SNF	18
Urine	19	Home	14
		Home Health Service	11
		Expired	7

Order Set by type September 2021

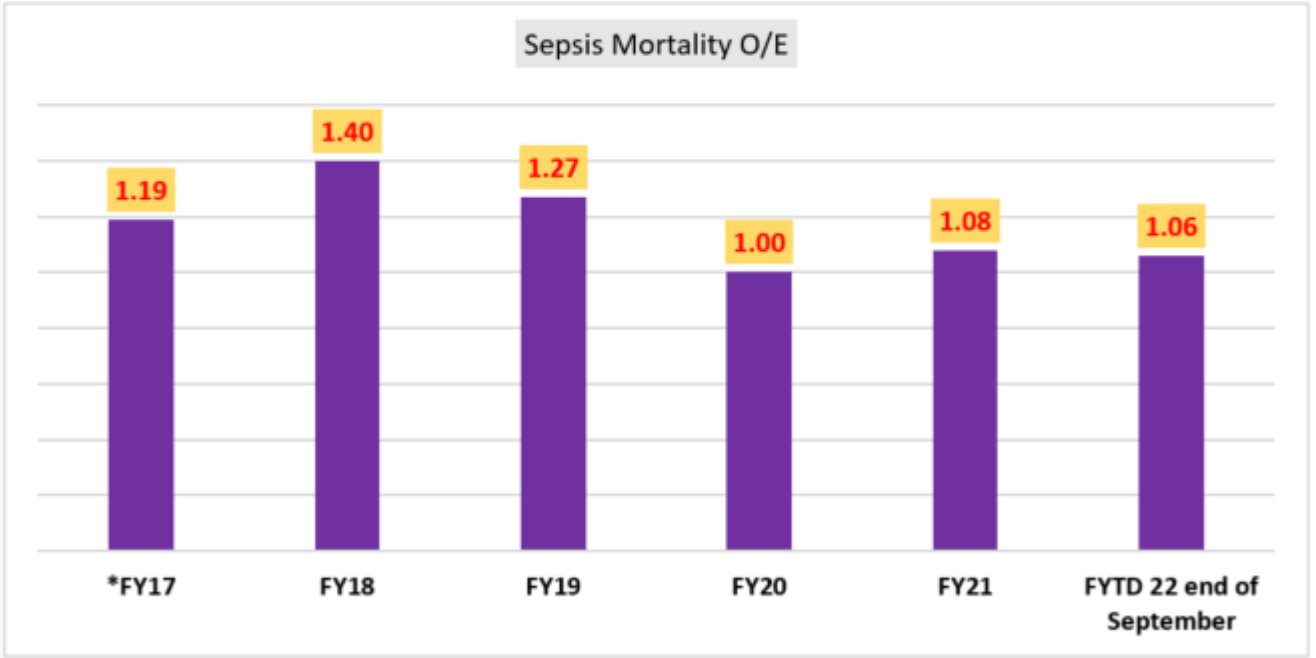


El Camino Health

Historical Perspective

Sepsis Mortality Trend: FY17 - FY22 end of September

FY	O/E
*FY17	1.19
FY18	1.40
FY19	1.27
FY20	1.00
FY21	1.08
FYTD 22 end of September	1.06



**FY17 data includes October 2016 - June 2017*

El Camino Health

Survival to Discharge Group

(refer to definitions in chart)

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

Note *higher* rate of:

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

Sepsis Program All Patients (except Mortality)

El Camino Health
Quality, Safety and Risk

ECH Monthly SEP-1 (All Patients) Aug 2021	ECH Compliance Rate September 2021	ALOS September 2021
56% *(9/16)* *Semple size 24*	49% *(n=26/53)*	6.64

Sepsis Bundle Metrics

	September 2021	August 2021	July 2021	June 2021	May 2021	April 2021	March 2021	February 2021	January 2021	December 2020	November 2020	October 2020
Lactate Drawn w/in 1 hr of TOP-Target 75%	89%	97%	92%	94%	100%	90%	96%	98%	91%	93%	98%	94%
Abx given within 1 hour of TOP- Target 75%	68%	86%	73%	69%	77%	81%	80%	82%	72%	74%	76%	78%
Blood cultures drawn prior to abx admin-Target 75%	89%	83%	88%	85%	82%	92%	96%	89%	87%	89%	96%	94%
Appropriate selection based on suspected source (1)	98%	100%	98%	96%	98%	96%	93%	98%	98%	98%	96%	100%
Was 30mL/kg cryst Fluid Given w/in 3 hours (2) - Target 90%	58%	78%	75%	83%	73%	74%	86%	59%	52%	79%	72%	71%
Repeat Lacate Done w/in 6 hrs (3) - Target 90%	95%	89%	95%	92%	100%	100%	98%	96%	95%	95%	92%	95%
Vasopressor administered for shock (4)	36%	50%	56%	83%	88%	50%	85%	44%	63%	29%	60%	33%
Norepi first choice (5)	100%	100%	100%	100%	100%	100%	100%	75%	80%	100%	89%	100%
MAP>=65 at 6 hours from TOP-Target 90%	89%	97%	87%	96%	89%	88%	89%	89%	89%	85%	82%	82%
Shock Re-assessment (6) - Target 75%	86%	100%	79%	75%	88%	82%	90%	83%	67%	85%	74%	74%
Sepsis Alert Rate	15%	8%	7%	8%	4%	12%	11%	13%	15%	2%	16%	14%
ECH Bundle Comp Rate	49%	66%	52%	56%	54%	65%	65%	54%	43%	63%	47%	46%

Order Set Used September 2021
49% (n=26/53)

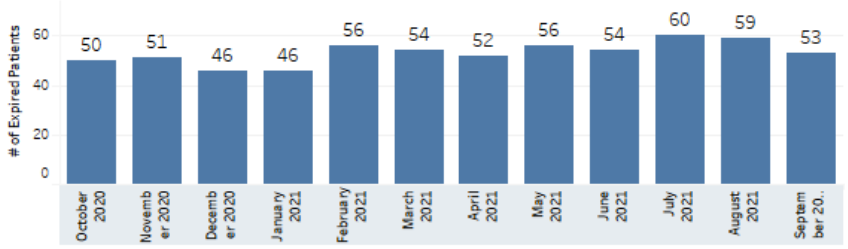
#1 Infection September 2021	
Lungs	14
Urine	17

TOP admitting units September 2021	
MV 2C MEDICAL	9
MV 3AC CCU	9
MV 3AP PCU	8

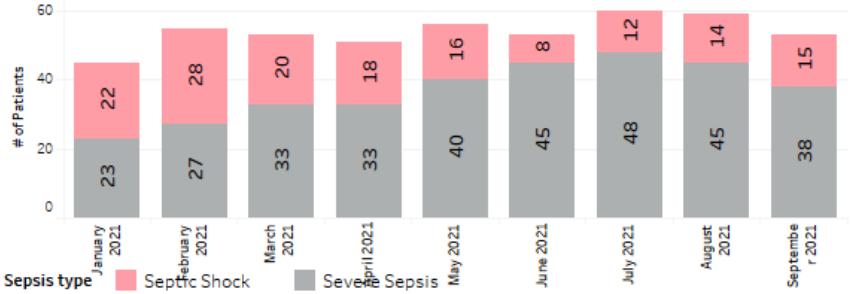
**Beginning with January 2021 data, the following changes were made:
- All COVID cases excluded (active, rule out, suspected)
- Abstraction method for 30 mL/kg fluid bolus administration time using criteria of 2 documented hypotensive readings (SBP<90 or MAP<65) within 3 hours of each other (do not need to be consecutive) OR initial lactate ≥ 4 mmol/L.

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

Monthly Sepsis All Patients (Except Mortality) Rolling 12 months



Sepsis Type - All Patients (except Mortality)



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

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

Mortality Group (observed, not risk adjusted)

Note ***higher*** rate of:
- Shock

Note ***lower*** rate of:
- Early antimicrobial therapy
- Fluid bolus
- Achieved perfusion target (MAP)
- Overall bundle compliance

Sepsis Program- Mortality Report

El Camino Health
Quality, Safety and Risk

ECH Monthly Mortality Index FYTD August 2021	ECH Compliance Rate September 2021	ALOS September 2021
1.06 *(10.88%/10.24%)* *Target 1.03*	14% *(n=1/7)*	3.43

Sepsis Bundle Metrics

	September 2021	August 2021	July 2021	June 2021	May 2021	April 2021	March 2021	February 2021	January 2021	December 2020	November 2020	October 2020
Lactate Drawn w/in 1 hr of TOP-Target 75%	86%	80%	100%	90%	100%	75%	100%	100%	86%	93%	85%	89%
Abx given within 1 hour of TOP- Target 75%	57%	60%	67%	50%	75%	75%	50%	100%	57%	93%	69%	67%
Blood cultures drawn prior to abx admin-Target 75%	86%	80%	83%	70%	100%	75%	67%	100%	86%	93%	69%	56%
Appropriate selection based on suspected source (1)	86%	100%	100%	90%	100%	100%	100%	83%	100%	93%	100%	89%
Was 30mL/kg cryst Fluid Given w/in 3 hours (2) - Target 90%	0%	75%	20%	60%	50%	63%	40%	25%	57%	86%	64%	43%
Repeat Lacate Done w/in 6 hrs (3) - Target 90%	80%	100%	100%	75%	100%	100%	100%	100%	83%	92%	82%	83%
Vasopressor administered for shock (4)	40%	100%	50%	33%		100%	100%	67%	60%	80%	89%	33%
Norepi first choice (5)	50%	100%	100%	100%		75%	67%	100%	100%	100%	88%	100%
MAP>=65 at 6 hours from TOP-Target 90%	29%	80%	67%	80%	100%	63%	67%	100%	57%	67%	77%	33%
Shock Re-assessment (6) - Target 75%	80%	67%	60%	60%	100%	88%	80%	100%	40%	100%	89%	60%
Observed mortality(not risk adjusted)	100%	100%	83%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Sepsis Alert Rate	29%	20%	0%	20%	0%	13%	17%	0%	0%	7%	8%	11%
ECH Bundle Comp Rate	14%	20%	17%	40%	50%	38%	17%	50%	29%	47%	38%	22%

Order Set Used September 2021
29% (n=2/7)

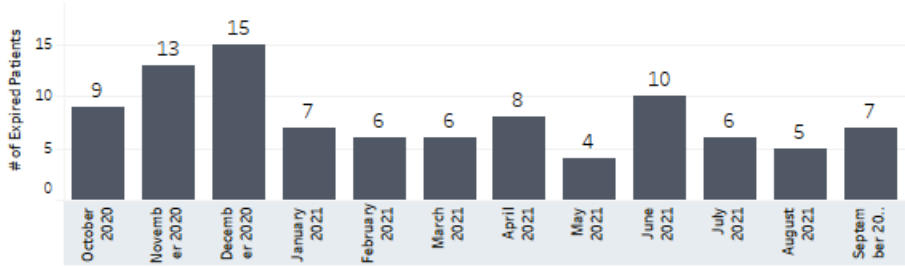
#1 Infection September 2021

IntraAbd	1
Lungs	1
Lungs/Urine	1
SSTI	3
Urine	1

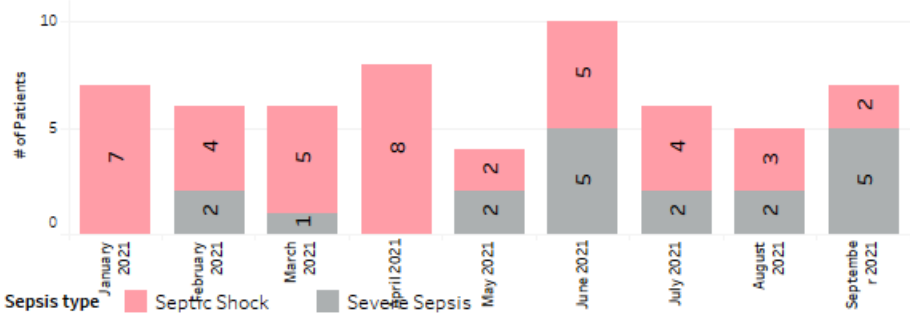
#1 admitting unit September 2021

LG L04 MED SURG	1
MV 3AC CCU	3
MV 3AP PCU	2

Monthly Sepsis Mortality October 2020-September 2021



Mortality Patients by Sepsis Type



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Data definition:
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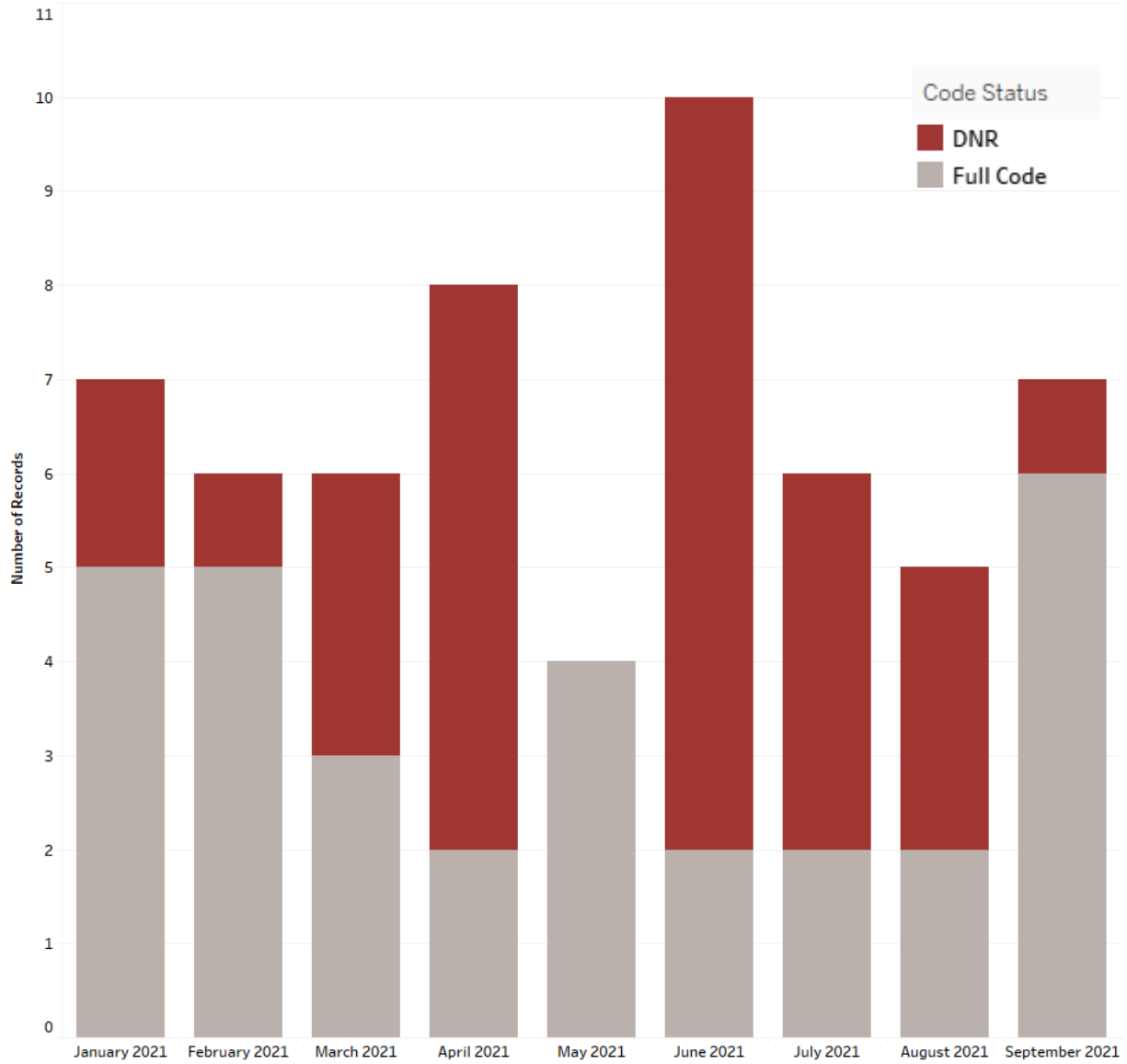
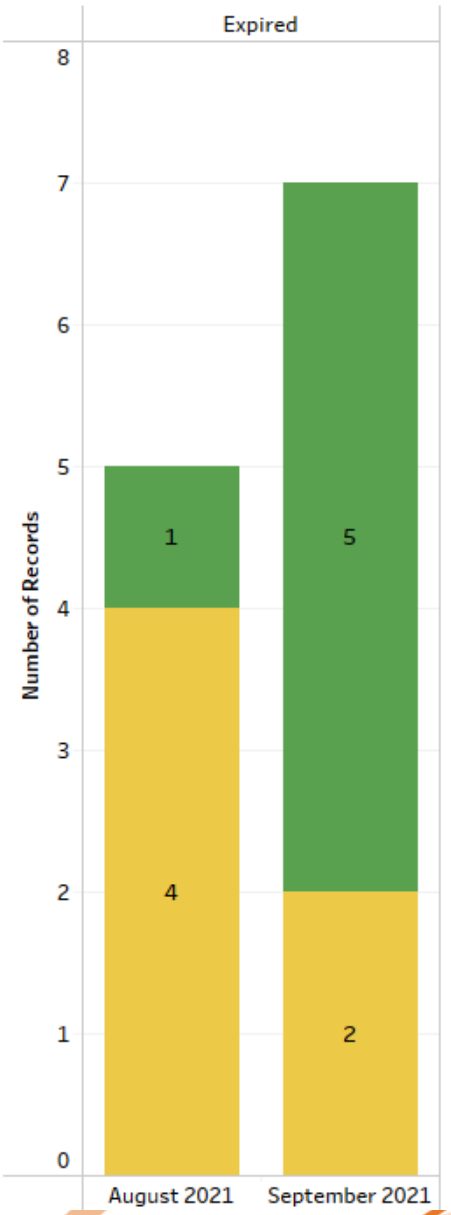
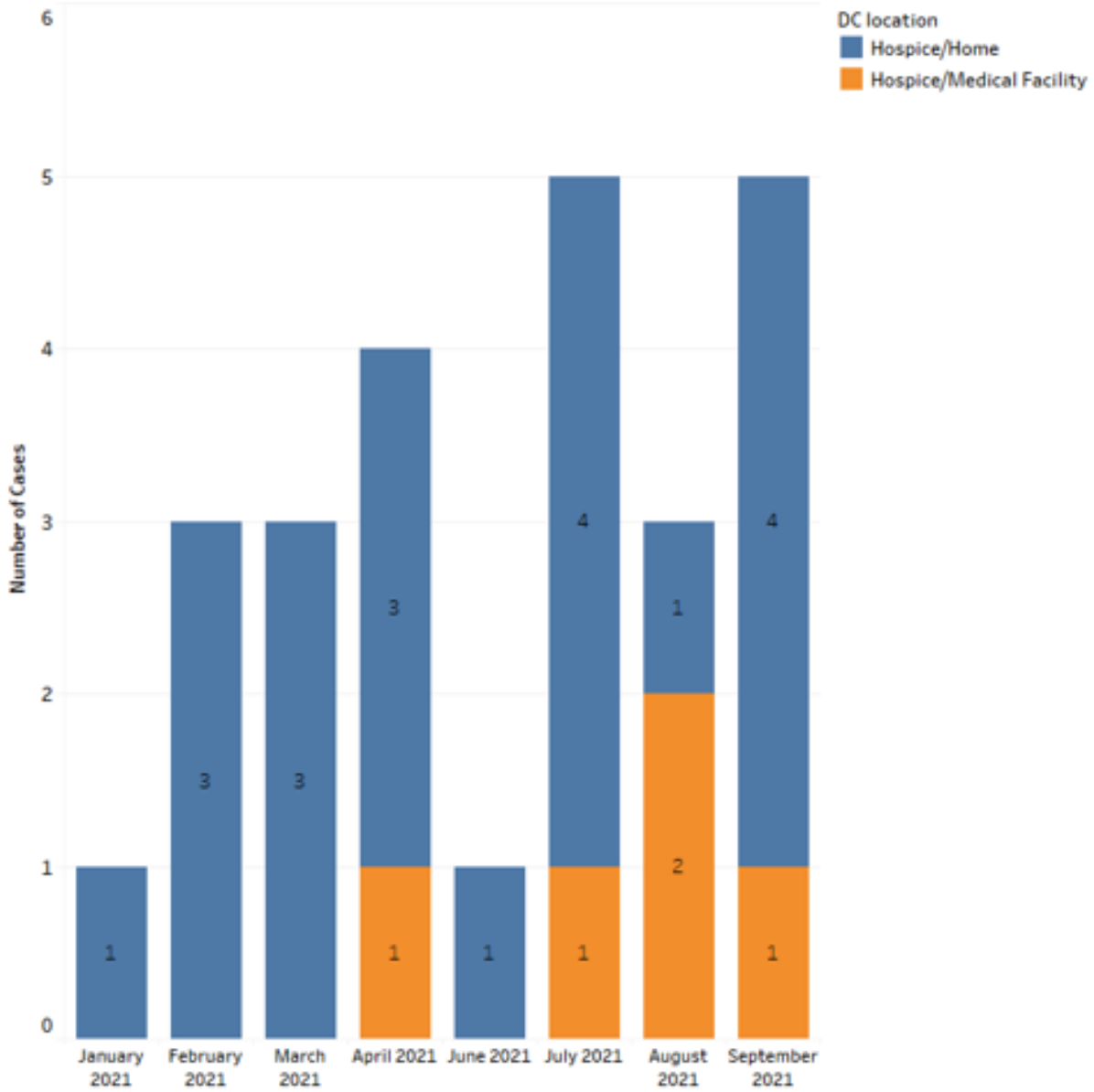
Sepsis Program-Mortality cases by Code Status at Admission
January - September 2021



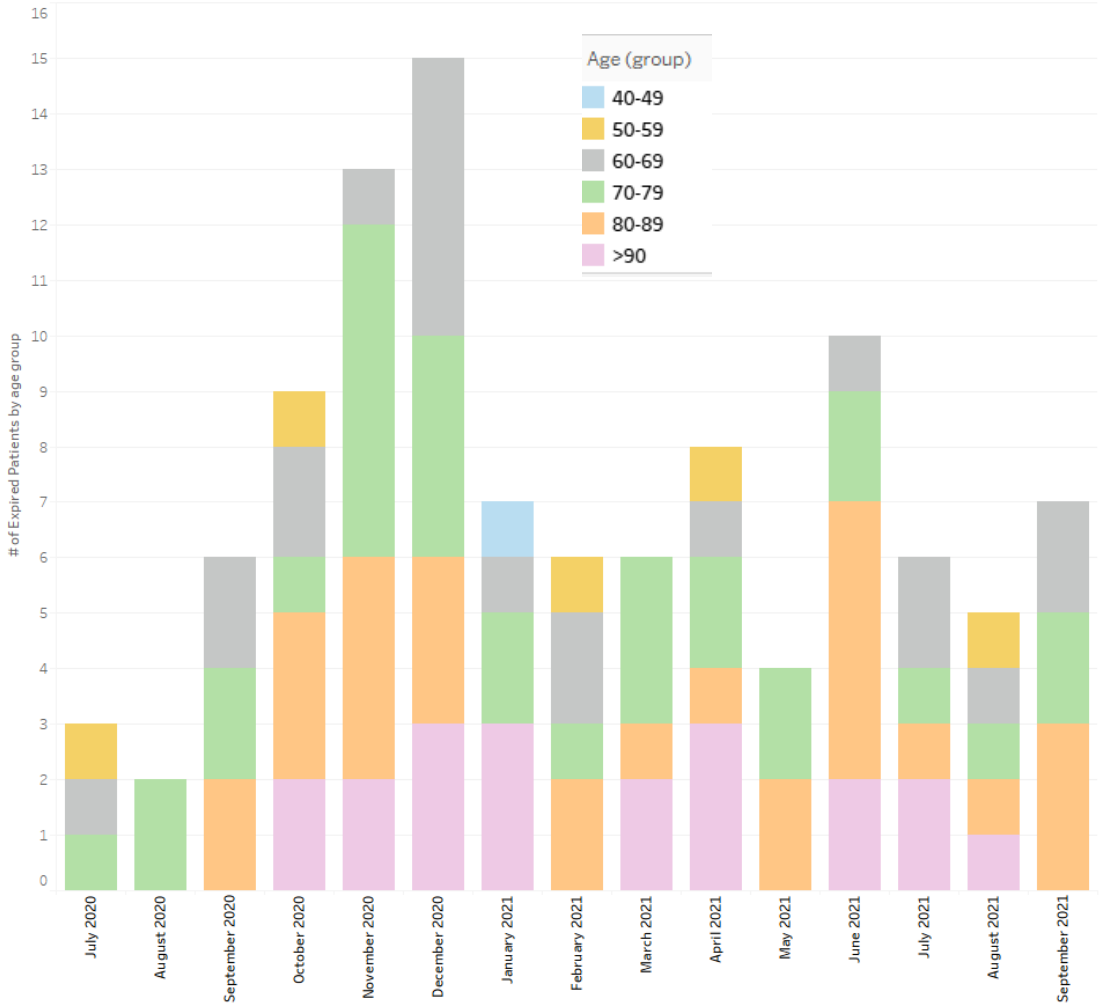
Expired Patients - Palliative Care only
August-September 2021



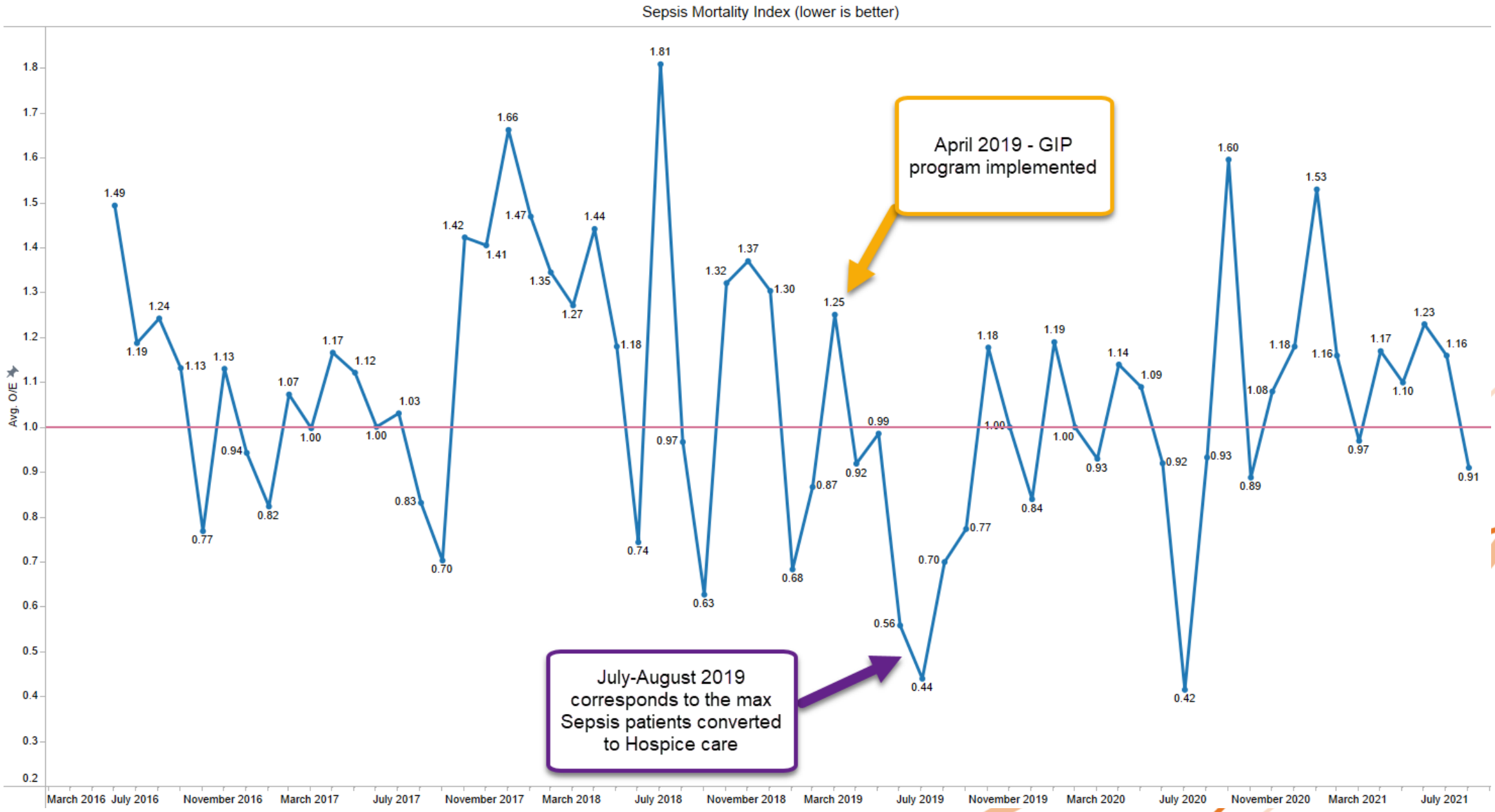
Sepsis Program: Discharge disposition: Hospice
January-September 2021



Sepsis Program- Mortality Patients by age group
July 2020-Sepember 2021

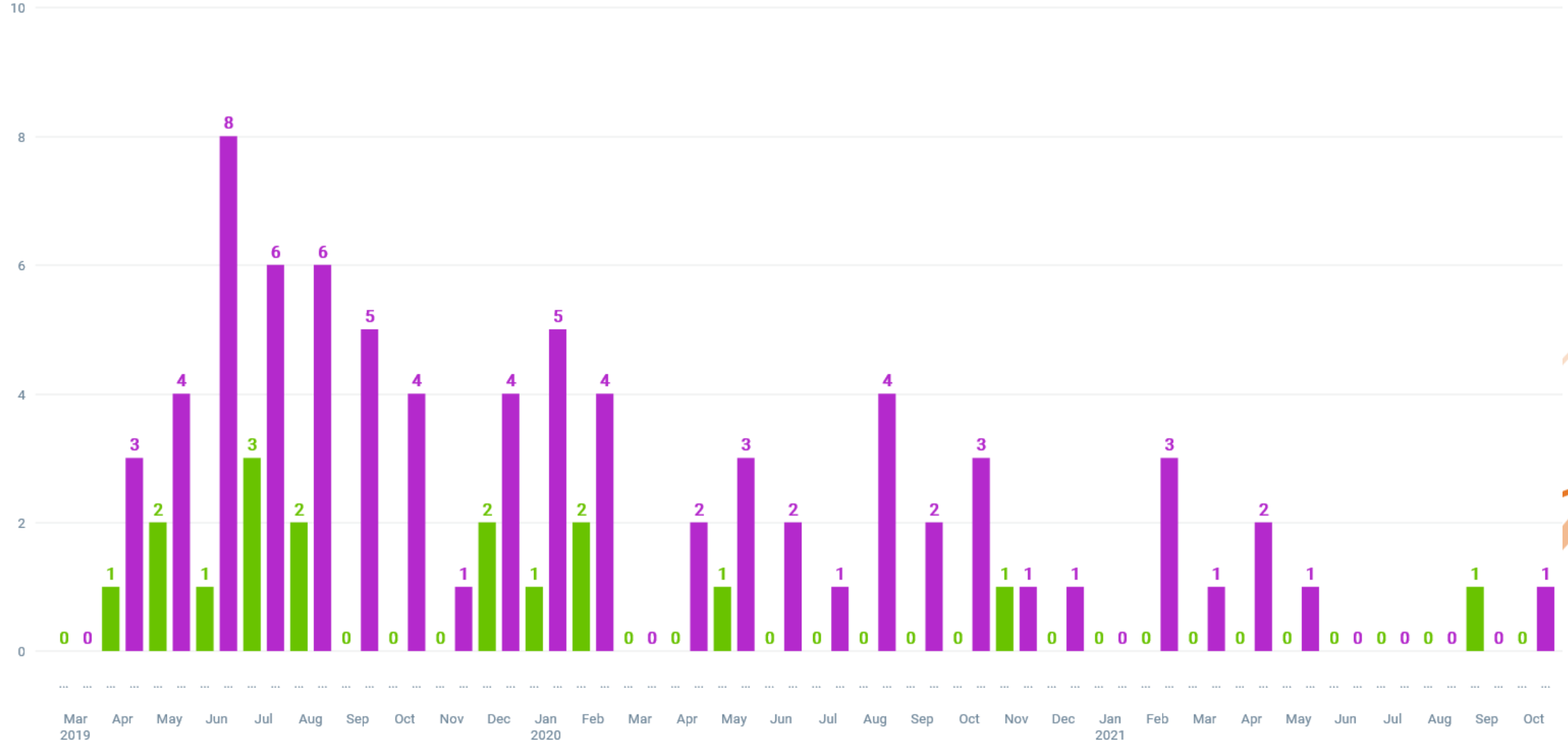


Month, Year of ..	40-49	50-59	60-69	70-79	80-89	>90	Grand To..
July 2020		1	1	1			3
August 2020				2			2
September 2020			2	2	2		6
October 2020		1	2	1	3	2	9
November 2020			1	6	4	2	13
December 2020			5	4	3	3	15
January 2021	1		1	2		3	7
February 2021		1	2	1	2		6
March 2021				3	1	2	6
April 2021		1	1	2	1	3	8
May 2021				2	2		4
June 2021			1	2	5	2	10
July 2021			2	1	1	2	6
August 2021		1	1	1	1	1	5
September 2021			2	2	3		7
Grand Total	1	5	21	32	28	20	107


Sepsis Mortality Index (lower is better)
Avg. O/E
April 2019 - GIP program implemented
July-August 2019 corresponds to the max Sepsis patients converted to Hospice care
March 2016
July 2016
November 2016
March 2017
July 2017
November 2017
March 2018
July 2018
November 2018
March 2019
July 2019
November 2019
March 2020
July 2020
November 2020
March 2021
July 2021

Patients converted to Hospice (green bars - Sepsis)

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



ECH Sepsis Program

El Camino Health

Quality, Safety and Risk

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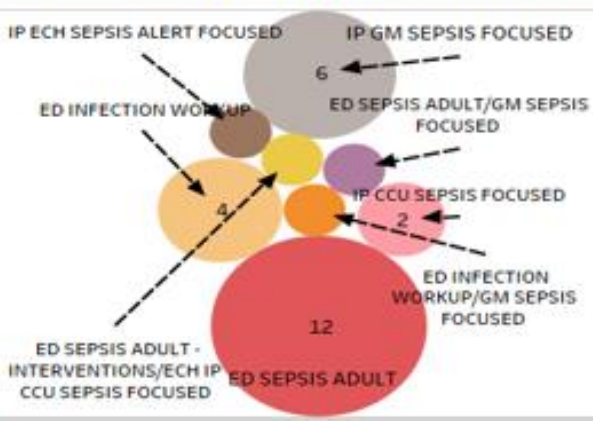
Blood cultures drawn prior to abx admin-Target 75%	87%	83%	88%	83%	83%	90%	93%	90%	87%	90%	91%	88%
Appropriate selection based on suspected source (1)	97%	100%	98%	95%	98%	97%	93%	97%	98%	97%	97%	98%
Was 30mL/kg cryst Fluid Given w/in 3 hours (2) - Target 90%	48%	78%	64%	76%	71%	70%	77%	56%	53%	81%	70%	66%
Repeat Lacate Done w/in 6 hrs (3) - Target 90%	93%	90%	96%	89%	100%	100%	98%	96%	93%	94%	90%	93%
Vasopressor administered for shock (4)	38%	67%	54%	67%	88%	70%	88%	50%	62%	50%	71%	33%
Norepi first choice (5)	75%	100%	100%	100%	100%	86%	93%	83%	88%	100%	88%	100%
MAP>=65 at 6 hours from TOP-Target 90%	82%	95%	85%	94%	90%	85%	87%	90%	85%	80%	81%	75%
Shock Re-assessment (6) - Target 75%	85%	95%	74%	69%	89%	84%	88%	85%	62%	89%	78%	72%
Observed mortality(not risk adjusted)	12%	8%	8%	16%	7%	14%	10%	10%	13%	25%	20%	15%
Sepsis Alert Rate	17%	9%	6%	10%	3%	12%	12%	11%	13%	3%	14%	14%
ECH Bundle Comp Rate	44%	63%	50%	53%	55%	65%	60%	53%	42%	59%	45%	42%

#1 Infection September 2021	
Lungs	15
Urine	19

Top D/C Locations September 2021	
SNF	18
Home	14
Home Health Service	11
Expired	7

Order Set by type September 2021



Accountability: Dr. Mark Adams

DRAFT FY22 Sepsis Mortality Goal

Objective:

To achieve Sepsis Mortality Index target of 1.03 by June 30, 2022

Goals:

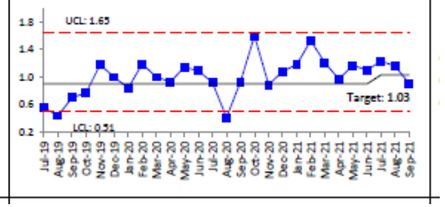
- Improve Sepsis Survivability of patients through improved Sepsis Bundle Compliance
  Early Identification and appropriate management in the initial hours after the development of sepsis improve outcomes (Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock 2021)
  Compliance with SEP-1 was associated with lower 3-=day mortality. Rendering SEP-1 compliant care may reduce the incidence of avoidable deaths (Townsend, et al, j.chest. 2021.072167)

- Improve Sepsis Mortality Index by removing Sepsis deaths that can be transferred into GIP .
  If a sepsis patient is terminal, transferring the patient into GIP will eliminate the death in the acute care hospital and reduce the sepsis mortality index.

Current Condition

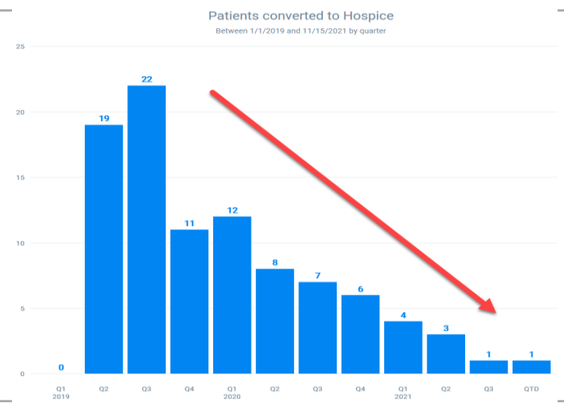
El Camino Health — Enterprise Quality, Safety, and Experience Dashboard

September 2021 (unless otherwise specified)

		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend (showing at least the last 24 months of available data)
		Latest month	FYTD			
9	Sepsis Mortality Index, based on ICD-10 codes (Observed over Expected) Latest data month: September 2021	0.91 (9.77%/10.70%)	1.06 (10.88%/10.24%)	1.08 (12.86%/11.87%)	1.03	

Historical Condition:

FY	O/E
*FY17	1.19
FY18	1.40
FY19	1.27
FY20	1.00
FY21	1.08
FYTD 22 end of September	1.06



Key Performance Indicators & Targets	
KPI	**Target FY22**
What will we measure/track monthly to show progress towards goals?	
See the monthly Sepsis dashboard for these metrics.	

Strategies

❖ Improve Clinical Care

•Increase 3 hr. bundle compliance – especially ABX with in 1 hr, , Fluid bolus, and MAP compliance
•Encourage provider attendance at 12/14 Townsend CME re: ECH reluctance re: fluid resuscitation
•Increase overall SEP-1 bundle compliance – 3hr + 6hr bundle
•Provide provider level data on bundle compliance by specialty and for OPPE
•Improve Order set usage
•Data on order set use by provider to Medicine Exec. Meeting
•Revised data for ED with new sepsis alert process and workflow
•Reduce wait time to transfer into CCU – from the ED and from the Floor
•More rapid acceptance of sepsis patients by intensivists
•Reduce hours of hypotension – improve more rapid use of vasopressors
•Vasopressors can be initiated with peripheral line

❖Improve Conversion of Terminal Sepsis cases to GIP

•Sepsis Navigator position to focus on improved communication w/patient, family & palliative care
•Encourage providers to document existing diagnosis on patient problem list so these diagnosis can be coded in this encounter even if not treated (history of cancer though admission is for sepsis)
•Provide education to Palliative care team regarding 6 month survivability of sepsis patients post hospitalization
•Encourage Palliative care team to approach all sepsis patients and family members who have DNR orders for conversations on end of life plans

Road Map: