El Camino Health

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

Monday, February 6, 2023 – 5:30 pm
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: 965 2541 0224#. 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**	Carol Somersille, MD Quality Committee Chair		**5:30 – 5:33pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair		**information** **5:33 – 5:34**
3.	**PUBLIC COMMUNICATION**	Carol Somersille, MD Quality Committee Chair		**information** **5:34 – 5:37**
4.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required** **5:37 – 5:47**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (12/12/2022) ***Information*** b. Report on Board Actions c. FY23 Pacing Plan d. FY23 Enterprise Quality Dashboard e. QC Follow-Up Items			
5.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer		**discussion** **5:47 – 5:57**
6.	**Q2 FY23 STEEEP DASHBOARD REVIEW**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion** **5:57 – 6:17**
7.	**EL CAMINO HEALTH MEDICAL NETWORK REPORT**	Shahab Dadjou, President, El Camino Health Medical Network Ute Burness, VP of Quality and Payer Relations		**discussion** **6:17 – 6:47**

A copy of the agenda for the Regular Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at **(650) 988-7609** prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
8.	**ADJOURN TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 6:47 – 6:48**
9.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair		**information 6:48 – 6:49**
10.	**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 (12/12/2022) ***Information*** *Health and Safety Code Section 32155* b. Quality Council Minutes (12/07/2022) c. Quality Council Minutes (1/04/2023)	Carol Somersille, MD Quality Committee Chair		**motion required 6:49 – 6:54**
11.	*Health and Safety Code Section 32155* **Q2 FY23 QUARTERLY QUALITY AND SAFETY REVIEW OF REPORTABLE EVENTS**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:54 – 6:59**
12.	*Health and Safety Code Section 32155* **CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer		**motion required 6:59 – 7:09**
13.	*Health and Safety Code Section 32155* **SERIOUS SAFETY/RED ALERT EVENT**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 7:09 – 7:14**
14.	*Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management:* **EXECUTIVE SESSION**	Carol Somersille, MD Quality Committee Chair		**discussion 7:14 - 7:24**
15.	**ADJOURN TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair		**motion required 7:24 - 7:25**
16.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair		**information 7:25 – 7:26**
17.	**ROUNDTABLE**	Carol Somersille, MD Quality Committee Chair		**discussion 7:26 – 7:29**
18.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 7:29– 7:30 pm**

Next Meeting: March 6, 2023, April 3, 2023, May 1, 2023, June 5, 2023

El Camino Health

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, December 12, 2022
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent	Others Present
Carol Somersille, MD	**Prithvi Legha,** MD	**Holly Beeman,** MD, MBA, CQO
Alyson Falwell**		**Meenesh Bhimani,** MD, COO
Philip Ho, MD		**Mark Adams,** MD, CMO
Jack Po, MD		**Cheryl Reinking,** DNP, RN, CNO
Krutica Sharma, MD**		**Deb Muro,** CIO**
Melora Simon		**Shahab Dadjou,** Interim President, ECHMN**
John Zoglin		**Shreyas Mallur,** MD, ACMO
		Lyn Garrett, Senior Director, Quality
		Daniel Shih, MD
	**via teleconference	**Christine Cunningham,** Chief Experience Officer
		Nicole Hartley, Executive Assistant II

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order at 5:31 pm by Chair Carol Somersille. A verbal roll call was taken. Dr. Sharma joined at 5:32 pm, Dr. Po joined at 5:33 pm, and Dr. Ho joined at 5:58 pm. Dr. Legha was absent. 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 Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. PUBLIC COMMUNICATION	There were no comments from the public.	
4. CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. Mr. Zoglin requested to pull item 4d – FY23 Enterprise Quality Dashboard. Ms. Falwell also requested to pull item 4d – FY23 Enterprise Quality Dashboard. Mr. Zoglin addressed item 4d – FY23 Enterprise Quality Dashboard and asked when we will meet quality goals for the measures on the dashboard, as they seem to be heading in the wrong direction.	***Consent Calendar Approved***

	Dr. Beeman shared that the items are impacted by volume and acuity and because volume and acuity vary, the timing of improvement in outcome measures is not reliably predictable. Every effort is being made to achieve our goals. A discussion occurred with the Committee regarding goals and targets. Chair Somersille transitioned the conversation to focus on what specific improvement efforts are being made to decrease C. Diff infections. She asked Dr. Shin to comment on C. Difficile infections. Dr. Shin shared that two important focus areas for C. Diff are hand hygiene and antibiotic stewardship. He shared the processes the hospital has put in place to screen patients and help prevent the spreading of C.Diff. Chair Somersille asked why we are going up. Dr. Shin responded that it is probably going up because of an increased antibiotic use during the COVID pandemic (most patients admitted with COVID received some type of antibiotic) and a decrease in hand washing. Mr. Zoglin stated the root cause analysis is great, but asked what the plan is to reach the target. Dr. Beeman answered that there is a plan that was presented at the December Hospital Board Meeting in great detail. She reminded members that for each HAC Index measure, there is an A3 and a team working on this issue. Dr. Adams shared that plans are in place and if they are not working then the plans are re-evaluated and updated based on the variables at hand. Ms. Falwell addressed item 4d – FY23 Enterprise Quality Dashboard and asked for more information on the Artificial Intelligence tool being used to better predict patients with increased fall risks. Cheryl Reinking, Chief Nursing Officer responded that currently every patient is assessed for fall risk using the Hendrich Fall Risk Scale which is heavily tested and is embedded into EPIC. EPIC presented a new tool utilizing A.I. to create a more sensitive, and real-time, tool for fall risk analysis. The hypothesis is that if the accuracy of fall risk is increased, those patients will have more timely and appropriate interventions put in place to decrease their risk of falling. Ms. Falwell addressed the inpatient HCAHPS scores and asked if they can be drilled down to the unit level to see what units may be struggling and see what units have higher scores and potentially learn from them. Ms. Cunningham shared that the drill down process occurs on a weekly basis and shared with the Committee what the process is. Ms. Falwell suggested to have that drill down shared with the Committee. **Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (11/07/2022); For information: (b) Report on Board Actions, (c) Progress against FY23 Committee Goals, (d) FY23 Enterprise Quality Dashboard, (e) QC Follow-Up items	

	Movant: Zoglin **Second**: Simon **Ayes**: Somersille, Falwell, Ho, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Legha **Recused**: None	
5. CHAIR'S REPORT	Chair Somersille thanked the Ad-Hoc Committee Members for their efforts with the Quality Committee Recruitment and the selection of the two candidates that the Committee will meet with today. Chair Somersille shared the work completed by the Ad-Hoc Committee and what to expect when interviewing the candidates.	
6. PATIENT STORY	Cheryl Reinking, CNO, shared a Press Ganey comment from a Patient who had a procedure with El Camino Health. The patient shared that she received excellent care but was told the wrong time for her procedure in the MyChart App. She ended up coming early to ensure she was on time. This issue has occurred in the past. A workgroup conducted a deep dive to see how we can create a frictionless experience for the Patients. A new process has been implemented and includes the following changes: 1. The schedule change cutoff is now 2:30 pm the day before 2. Each patient receives a call after that cutoff time to confirm his or her procedure time 3. Update the MyChart App with the new time This process has been successful so far and will continue to be monitored.	
7. PATIENT EXPERIENCE – 5 YEAR ANALYSIS	Christine Cunningham, Chief Experience Officer presented on the Patient Experience – 5 Year Analysis and highlighted the following: • ECH Partnering with Press Ganey • Inpatient 5 year trend • National HCAHPS 5 Year Trend • Loyalty – Likelihood to Recommend (LTR) • Partnering with Press Ganey on Goal Setting • Rates of change – the amount of improvement recommended based on Press Ganey • Statistical Significance • Enterprise Level – 5 Year Z Test Christine also shared additional information about the Global Experience Metric (GEX) Update. Ms. Simon inquired if in the future she could see both the Press Ganey results and the HCAHPS Hospital Compare data.	

	Christine explained the shortcoming of the Hospital Compare method and timing. This data has a small sample of patients being surveyed and lags by more than a year.	
8. PSI REPORT	Lyn Garrett, Senior Director of Quality presented the PSI Report and highlighted the following: • PSI-04 Death in Surgical Patients with treatable complications – A deep dive is being conducted. There have been 6 cases in FY 23. • PSI-12 Perioperative PE and DVT - the rate doubled for FY 23. A review of the process of identification and management of DVTs is underway.	
9. SEPSIS MORTALITY INDEX	Dr. Daniel Shin, Director of Medical Quality presented the Sepsis Mortality Index and highlighted the following: • FY23 Sepsis Mortality Index Dashboard • Historical Perspective (FY21-FY23) • SEP – 1 Core Measure • Survival to Discharge Group • Mortality Group (Observed, not risk adjusted) • Mortality Patients by age group • Mortality cases by code status at Admission • Discharge Disposition: Hospice • Sepsis Mortality Index (03/2016-07/2021) • Patients converted to Hospice • Overall Summary/Findings from FY22 data analysis and feedback from clinicians • Sepsis Program Initiatives	
10. QUALITY COMMITTEE CANDIDATE CONSIDERATIONS & APPOINTMENT	Chair Somersille introduced candidate Terhilda Garrido to the Committee and shared her answers from the questionnaire completed by Terhilda. Chair Somersille and the committee members interviewed finalist Terhilda Garrido for the Quality, Patient Care, and Patient Experience Committee membership. Chair Somersille introduced candidate Pancho Chang to the Committee and shared his answers from the questionnaire completed by Pancho. Chair Somersille and the committee members interviewed finalist Pancho Chang for the Quality, Patient Care, and Patient Experience Committee membership. A debrief occurred with the Committee regarding finalists Terhilda Garrido and Pancho Chang. **Motion**: To recommend for board approval the appointment of candidate Terhilda Garrido to the Quality, Patient Care, and Patient Experience Committee. **Movant**: Zoglin **Second**: Po **Ayes**: Somersille, Falwell, Ho, Po, Sharma, Simon, Zoglin **Noes**: None	***Recommendation for board approval to appoint Terhilda Garrido approved*** ***Recommendation for board approval to appoint Pancho Chang approved***

	Abstain: None **Absent**: Legha **Recused**: None **Motion**: To recommend for board approval the appointment of candidate Pancho Chang to the Quality, Patient Care, and Patient Experience Committee. **Movant**: Simon **Second**: Po **Ayes**: Somersille, Falwell, Ho, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Legha **Recused**: None	
11. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 7:30 pm. **Movant**: Zoglin **Second**: Po **Ayes**: Somersille, Falwell, Ho, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Legha **Recused**: None	***Adjourned to closed session at 7:30 pm***
12. AGENDA ITEM 16: RECONVENE OPEN SESSION/REPORT OUT	The open session reconvened at 7:43 pm. Agenda items 12-15 were addressed in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (11/07/2022) and the Quality Council Minutes (11/02/2022) by unanimous vote by all committee members present.	
13. AGENDA ITEM 17: CLOSING WRAP UP	No additional comments.	
14. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 7:44 pm **Movant**: Zoglin **Second**: Po **Ayes**: Somersille, Falwell, Ho, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Legha **Recused**: None	***Adjourned at 7:44 pm***

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Carol Somersille, MD
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: Tracy Fowler, Director Governance Services
Date: February 6, 2023
Subject: Report on Board Actions

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

Summary:

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 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 and the District did not meet. In addition, since the Board has delegated specific authority to the Executive Compensation Committee, the Compliance and Audit Committee, and the Finance Committee, those approvals are also noted in this report for any meetings since the last Quality Committee meeting.

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
Finance Committee	January 30, 2022	- FY23 Period 6 Financial Report - Hospitalist Professional Services Renewal Agreement (LG) - Hospitalist Professional Services Agreement (MV) - Plastic Surgery Per Activation Professional Services Agreement (LG) - Anesthesia Services Agreement

El Camino Health

Quality, Patient Care, and Patient Experience Committee

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

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

El Camino Health

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

To: Quality, Patient Care and Patient Experience Committee
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: February 6, 2023
Subject: Enterprise Quality, Safety and Experience Dashboard through December 2022

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety and experience metrics and performance December 2022 (unless otherwise noted) as demonstrated on the FY23 Enterprise Quality, Safety and Experience Dashboard.

Summary:

1. Situation: The Fiscal Year 2023 Enterprise Quality, Safety, and Experience dashboard is used throughout the organization to illustrate, track, and communicate a key set of metrics to align the quality, safety, and experience improvement work. These key metrics were selected based on a review of the organizational incentive goals, strategic goals, and areas of concern based on standardized benchmarks. These are not the only metrics that are tracked but represent the highest priority for the organization. This memo and the attached dashboard provide the Committee with a snapshot of the FY 2023 metrics monthly with trends over time and compared to the actual results from FY2022 and the FY 2023 targets.

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

4. Assessment: Please see FY23 Quarterly Board Quality Dashboard (STEEEP) memo.

List of Attachments

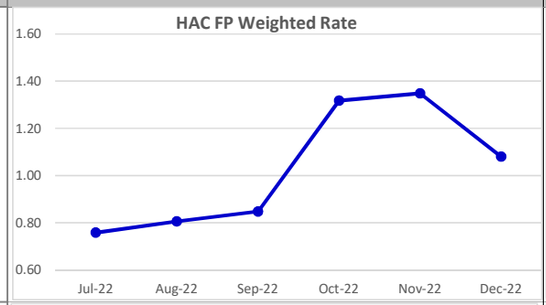
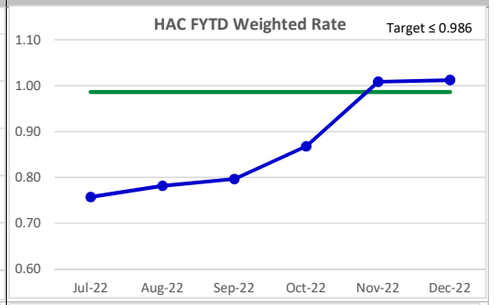
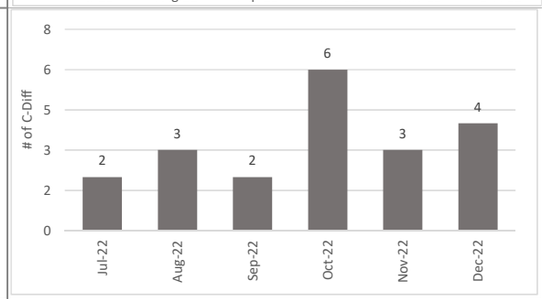
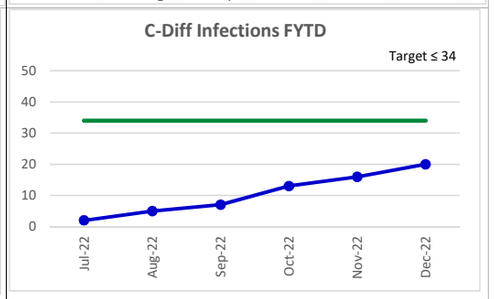
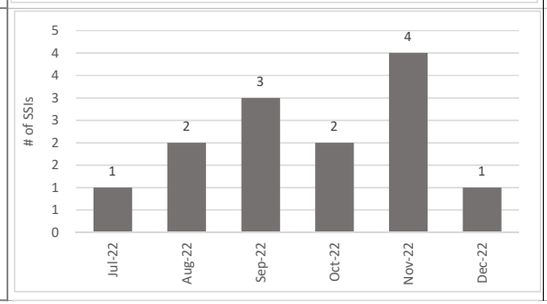
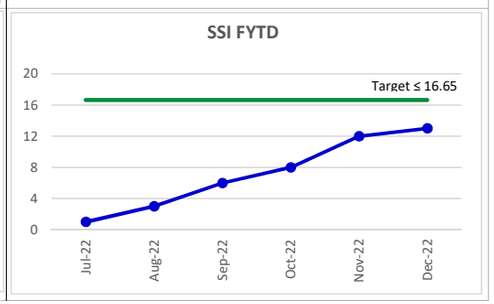
Attachment 1-- Enterprise Quality, Safety, and Experience Dashboard December 2022

El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

December 2022 (unless otherwise specified)

Month to Board Quality Committee:
February, 2023

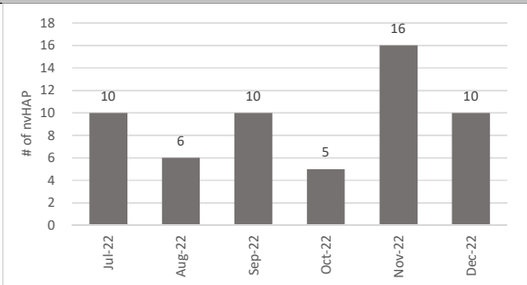
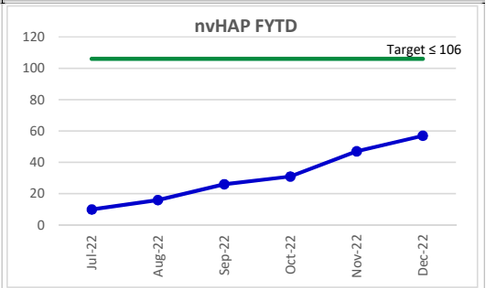
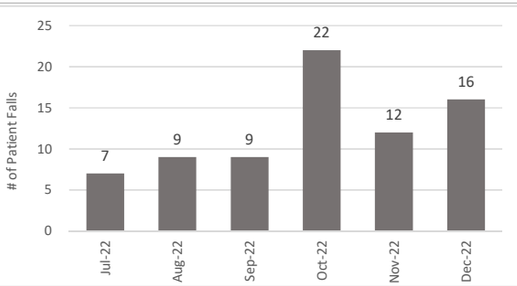
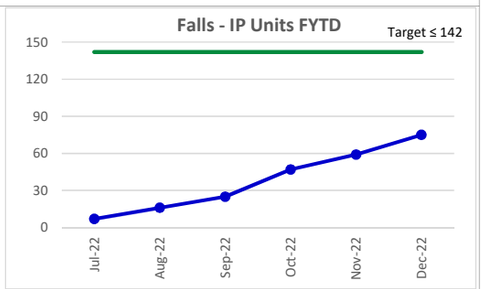
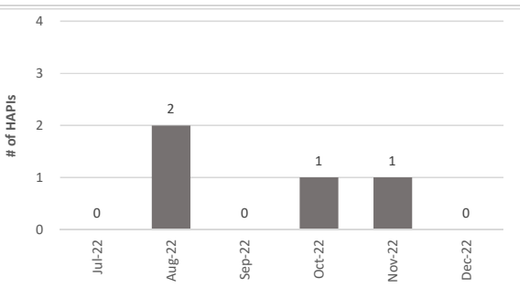
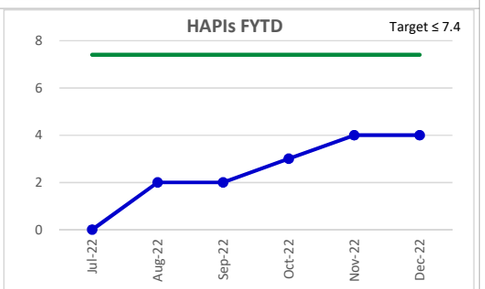
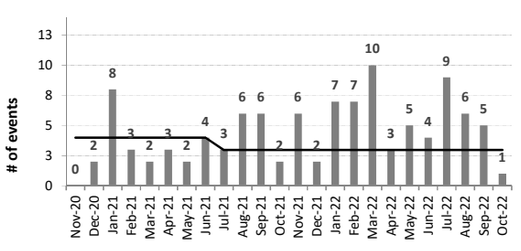
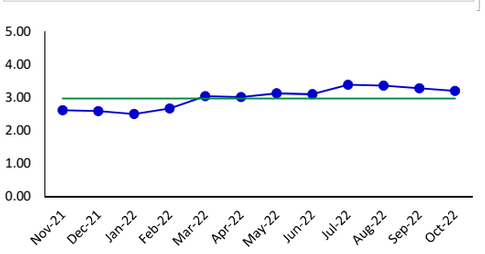
		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **HAC Index** *Latest data month: Dec, 22*	1.08	1.01	1.066	0.986 (7.5% ↓)		
2	**HAC component** **Clostridium Difficile Infections (C-Diff)** *Latest data month: Dec, 22*	4	3.33 / month	3.08 / month	2.85 / month		
3	**HAC component** **Surgical Site Infections (SSI)** *Latest data month: Dec, 22*	1	2.17 / month	1.50 / month	1.39 / month		

El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

December 2022 (unless otherwise specified)

Month to Board Quality Committee:
February, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
4	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: Dec, 22*	10	9.50 / month	9.58 / month	8.86 / month		
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: Dec, 22*	16	12.50 / month	12.75 / month	11.79 / month		
6	**HAC component** **HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury** *Latest data month: Dec, 22*	0	0.67 / month	0.67 / month	0.62 / month		
7	**Serious Safety Event Rate (SSER)** **Latest data month: Oct, 22*	1	3.20 (65/203389)	3.10 (Jul, 21 - Jun, 22)	TBD		

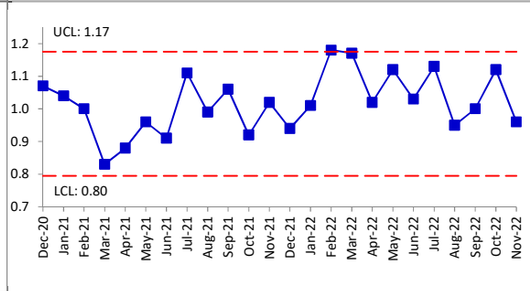
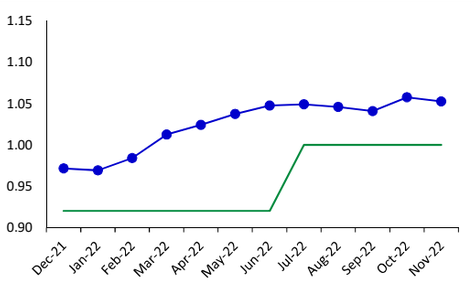
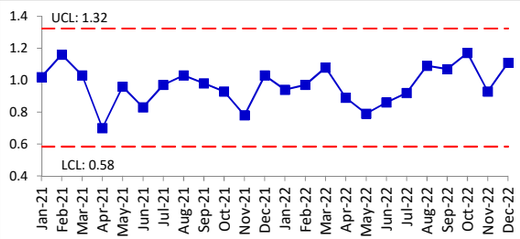
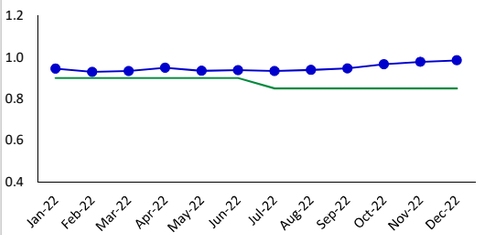
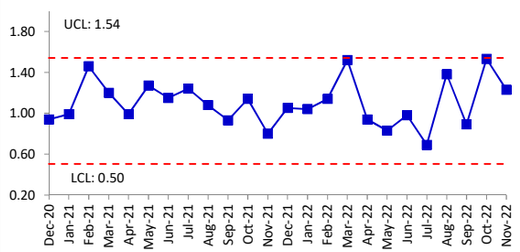
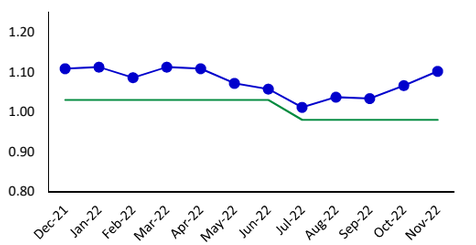
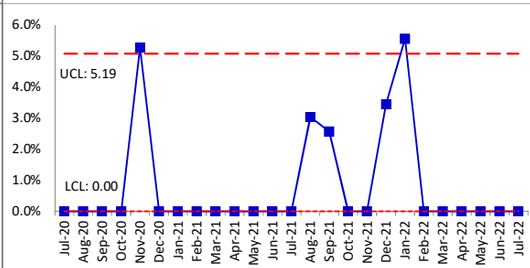
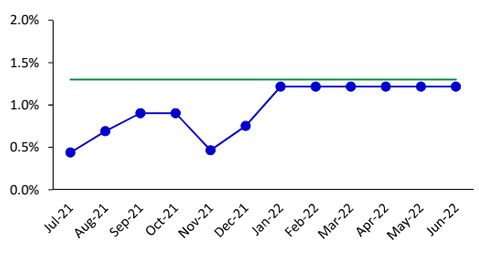
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

December 2022 (unless otherwise specified)

Month to Board Quality Committee:

February, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
8	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** ** Latest data month: Nov, 22*	0.96 (8.74%/9.13%)	1.03 (8.97%/8.71%)	1.05	1.00		
9	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Dec, 22*	1.11 (3.04%/2.73%)	1.05 (2.02%/1.92%)	0.94	0.85		
10	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Dec, 22*	1.13 (17.88%/15.84%)	1.14 (13.20%/11.55%)	1.03	0.98		
11	**PC-01: Elective Delivery Prior to 39 weeks gestation** (reported quarterly) **Latest data quarter: Jun, 22*	MV: 0.0% (0/27) LG: 0.0% (0/11) ENT: 0.0% (0/38)	MV: 0.4% (1/271) LG: 3.5% (3/83) ENT: 1.1% (4/356)	MV: 0.41% (1/244) LG: 0.0% (0/77) ENT: 0.3% (1/321)	1.3% (FY22 Target)		

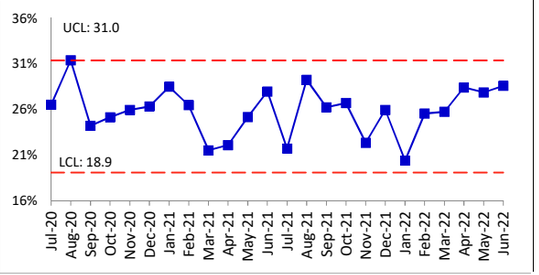
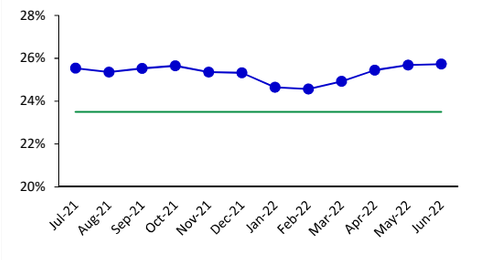
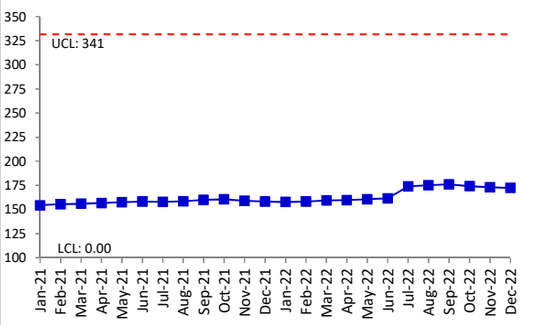
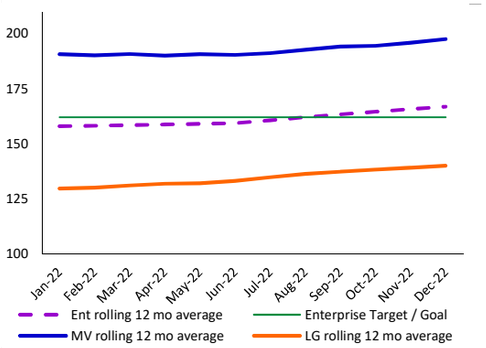
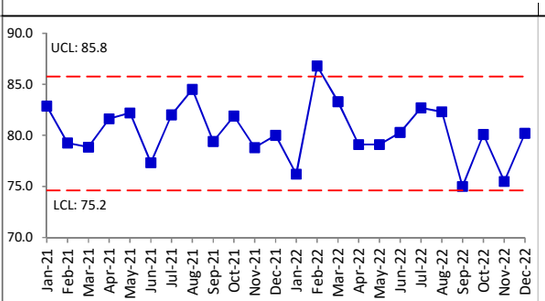
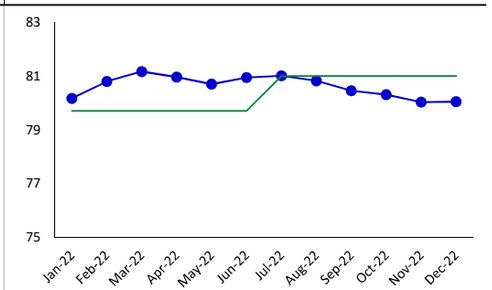
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

December 2022 (unless otherwise specified)

Month to Board Quality Committee:

February, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
12	**PC-02: Cesarean Birth** (reported quarterly) **Latest data quarter: Jun, 22*	MV: 30.3% (44/145) LG: 20.0% (6/30) ENT: 28.6% (50/275)	MV: 27.1% (503/1,857) LG: 19.9% (83/147) ENT: 25.8% (586/2,274)	MV: 27.3% (423/1551) LG: 20.6% (72/349) ENT: 26.10% (495/1900)	23.5% (FY22 Target)		
13	**OP18b: Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: Dec, '22*	MV: 197 mins LG: 140 mins ENT: 169 mins	MV: 202 mins LG: 143 mins ENT: 172 mins	MV: 190 mins LG: 133 mins Ent: 162 mins	MV: 190 mins LG: 133 mins Ent: 162 mins		
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Dec, 22*	80.2	79.4	80.8	81.0		

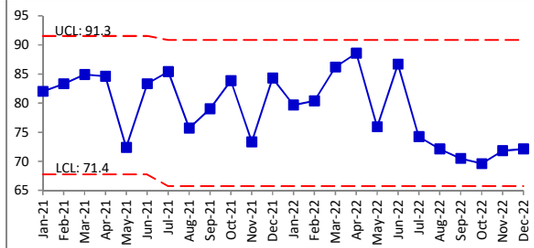
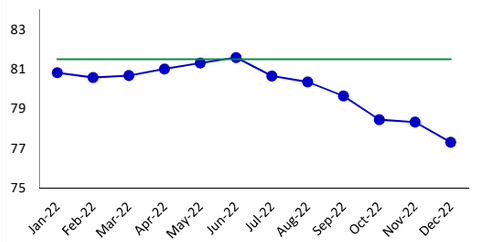
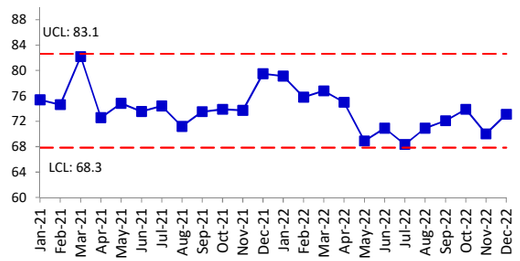
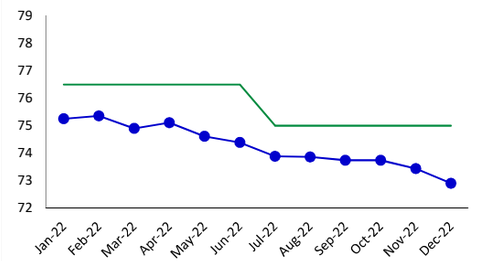
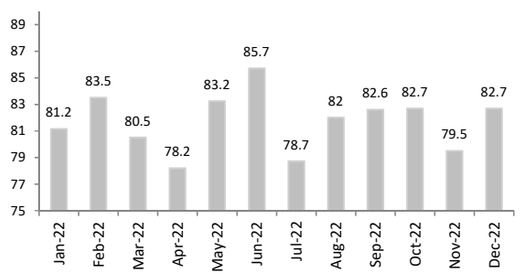
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

December 2022 (unless otherwise specified)

Month to Board Quality Committee:

February, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
15	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Dec, 22*	72.1	71.8	81.3	81.5		
16	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: Dec, 22*	73.1	71.3	74.5	75.0		
17	*** Organizational Goal** **ECHMN (El Camino Health Medical Network) : Likelihood to Recommend Care Provider** **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Unadjusted** *Latest data month: Dec, 22*	82.7	81.4	83.2	83.4		NA

Notes:

1) SSER through Oct, 22

2) Readmissions through Nov, '22

3) PC-01 & PC-02 FY22 final results reported; FY23Q1 will be available after 2/1/23

4) ECHMN: reflect new vendor (PG) survey results

5) Updated 1/23/23

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
1	*Organizational Goal **HAC Index** *Latest data month: Dec, 22*		H. Beeman, MD	New for FY23, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (5) key inpatient safety events. The elements of the composite are weighted as noted: Falls 20%, hospital-acquired Pressure Injuries (HAPIs) 25%, non-ventilator hospital-acquired pneumonia (nvHAP) 20%, Clostridium difficile infections (C-Diff) 10%, and surgical site infections (SSIs) 25%.	See below
2	HAC component **Clostridium Difficile Infections (C-Diff)** *Latest data month: Dec, 22*		C. Nalesnik	1) Based on NHSN defined criteria: inclusions: Inpatients, Peri-Op, Behavioral Health; exclusions: Rehab, NICU, outpatients, ED patients 2) All positive C.diff Toxin/antigen lab tests that result on or after the patient's 4th day of hospitalization 3) Latency: C-Diff infections may be identified up to 30 days, thus previously reported results may change.	Numerator: Infection control Dept. Denominator: EPIC Report
3	HAC component **Surgical Site Infections (SSI)** *Latest data month: Dec, 22*		C. Nalesnik	1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty". 4) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. 5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.	Numerator: Infection control Dept. Denominator: EPIC Report

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
4	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: Dec, 22*		C. Delogramatic	1) Internal metric: Inpatient non-ventilator hospital-acquired pneumonia cases. 2) Numerator inclusions: inpatients (18+yrs) w/ a specified pneumonia diagnosis code(s) with POA (present on admission) status of "N" (acquired during the hospital encounter), that is unrelated to mechanical ventilation; monthly, cases are reviewed & confirmed by the nvHAP workgroup. 3) Denominator EPSI patient days excluding 6070 NICU/Nursery Lvl 2, 6310/6315 MBU, 6340 Behavioral Health, 6440 IP Rehab, 6900 Pre-Op SSU, 7400 L&D, 7427 PACU 5) Latency: periodic; corrections may change previously reported results.	EPIC Clarity data warehouse; Numerator identified by nvHAP workgroup; Denominator: EPSi patient days
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: Dec, 22*		Nursing	1) NDNQI metric: In or outpatient falls on an inpatient nursing unit. "Falls" in a nursery are 'drops'. 2) Numerator inclusions: Patient falls as determined by a monthly evaluation & validation of iSAFE incident reports. 3) Numerator exclusions: L&D, intentional falls. 4) Denominator: EPSi acute patient days excluding: 6900 Pre-OP/SSU, 7400 L&D, 7427 PACU 5) Formula: (# falls/patient days) * 1,000 6) Latency: rare; corrections may change previously reported results.	Numerator: Incident Reports and Staff Validation/iSafe Denominator: EPSi patient days
6	**HAC component** **HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury** *Latest data month: Dec, 22*		A. Aquino	1) Internal metric: Inpatient Stage 3, Stage 4 & Unstageable hospital-acquired pressure injuries 2) Numerator exclusions: Expirations, "skin failure/ Kennedy Pressure Ulcer" & proned Covid-19 patients 3) Denominator: EPSi acute patient days excluding 6070 NICU/Nursery Lvl 2, 6900 Pre-Op SSU,7400 L&D, 7427 PACU 4) Latency: periodic; corrections may change previously reported results.	Numerator: EPIC Report and staff validation Denominator: EPSi patient days
7	**Serious Safety Event Rate (SSER)** **Latest data month: Oct, 22*		S. Shah	1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. 2) Inclusions: events determined to be serious safety events per Safety Event Classification team 3) NOTE: the count of SSE HAPIs MAY differ from internally-tracked HAPIs 4) Denominator: EPSI Acute Adjusted Patient Days For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HPI Systems

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
8	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** ** Latest data month: Nov, 22*		H. Beeman, MD	1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause). 2) Based upon Premier's Care Sciences Standard Practice risk-adjustment + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient 4) NOTE: Excludes cases discharged from (1) hospital, then readmitted to the other hospital w/in 30D. For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Premier Quality Advisor
9	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Dec, 22*		H. Beeman, MD	1) Based upon Premier's Care Sciences Standard Practice RA for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient; exclusions: Patient Type = Rehab, Psychiatric or Hospice. For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= to zero.	Premier Quality Advisor
10	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Dec, 22*		J. Harkey, H. Beeman, MD	1) Numerator inclusions: Patient Type = Inpatient, Prin or 2nd diagnosis of sepsis & age 18+ yrs 2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB) For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Premier Quality Advisor
11	**PC-01: Elective Delivery Prior to 39 weeks gestation** (reported quarterly) *****Latest data quarter: Jun, 22*		H. Beeman, MD	1) Numerator: Patients with elective deliveries 2) Denominator: Delivered newborns with gestation weeks >/= 37 to 39 weeks For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value ,/= zero. 9/16/22 (per H. Freeman): The FY23 target for PC-01 1.5% (top 25th %ile for MDC). MCH needs to retain some ability to do medically indicated, yet not meeting criteria, early deliveries.	IBM CareDiscovery Quality Measures

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
12	**PC-02: Cesarean Birth** (reported quarterly) *****_Latest data quarter: Jun, 22_		H. Beeman, MD	1) Numerator: Patients with cesarean births 2) Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value ,/= zero. 9/16/22 (per H. Freeman): FY23 target for PC-02 NTSV is 23.9%. Given our population (Asian average in CA was 25.2% from 07/2021-06/2022 for same nursery level CA MDC, + have significantly older population than CA), we think this is pretty aggressive.	IBM CareDiscovery Quality Measures
13	**OP18b: Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** _Latest Data Month: Dec, '22_		J. Baluom	ED Arrival to ED Departure (TAT-D - Direct Discharge): This metric is the median arrival to patient discharged time from ED. This metric excludes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery Patients who arrive via the ED. **Time stamp is used for this calculation:** ED Arrival - Patient Arrived in ED (50) (ADT_ARRIVAL_DTTM in Clarity "F_ED_ENCOUNTERS" table) ED Departure Time - "ED_Departure_DTTM" in Clarity "F_ED_ENCOUNTERS" table	EDSBAR Tableau Dashboard; EDOC Monthly Meeting Dashboard
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** _Latest data month: Dec, 22_		C. Cunningham	1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. 2) Inclusions: Inpatient nursing units; excludes: MBU. 3) Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
15	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Dec, 22*		C. Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS
16	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: Dec, 22*		C. Cunningham	ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted' For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey
17	*** Organizational Goal** **ECHMN (El Camino Health Medical Network) : Likelihood to Recommend Care Provider** **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Unadjusted** *Latest data month: Dec, 22*		C. Cunningham	Switched Vendor NRC to PressGaney in January 2022. Started reporting in FY 23 dashboards 'Top Box, Received Date, and Unadjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey

Notes:

1) SSER through Oct, 22
2) Readmissions through Nov, '22
3) PC-01 & PC-02 FY22 final results reported
4) ECHMN: reflect new vendor (PG) survey
5) Updated 1/23/23

As of: 1/30/23

Quality Committee Follow-Up Items

Item	Date Requested	Committee Member Name	Item Requested	Individual to complete the follow up	Completion Date
	FY22				
1	2/7/2022	Krutica Sharma, MD	Please add the definitions back onto the Enterprise Dashboard	Dr. Holly Beeman	3/7/2022
2	2/7/2022	Krutica Sharma, MD	Please include the Red Flags for the Medical Staff Credentialing Privileges Report	Dr. Mark Adams	3/7/2022
3	3/7/2022	Julie Kliger	Follow up Disscussion - Include patients in Quality Committee Meetings. Dr. Burn, Cheryl and Dr. Beeman will explore other models of this process.	Cheryl Reinking /Dr. Holly Beeman	
4	4/4/2022	Holly Beeman, MD	Update FY23 Quality Committee Goals to include: DEI, HRO	Dr. Holly Beeman	5/2/2022
5	6/6/2022	Carol Somersille, MD	FY 22 Enterprise Quality Dashboard, Dr. Somersille referenced page 14, likelihood to recommend care provider, and asked what is the average of this metric. Dr. Beeman shared that she can look into this and report back at the next meeting.	Dr. Holly Beeman	8/1/2022
	FY23				
6	9/6/2022	Carol Somersille, MD	4d – Progress Against FY23 Committee Goals. She noted to correct the Chair name to her name and remove Julie Kliger's name.	Nicole Hartley	9/7/2022
7	9/6/2022	Carol Somersille, MD	4e – QC Follow-Up Items. She noted to correct the Committee Member Name on the item dated 06/06/2022 to her name and remove Holly Beeman's name	Nicole Hartley	9/7/2022
8	11/7/2022	John Zoglin	Please add the follow up items from the 9/6/22 Quality Committee Meeting for Agenda Item 7. Follow up items are: Present a 5-year analysis to the Committee and a status update on the deciles.	Nicole Hartley/Christine Cunningham	12/12/2022
9	11/7/2022	Alyson Falwell	Request for further explanation of Core Measure OP-23 (Imaging turnaround time for stroke patients evaluated and discharged from ED) performance as shared in Core Measure report during the Nov 2022 Quality Committee Meeting.	Dr. Holly Beeman	12/12/2022
10	11/7/2022	Melora Simon	Requests to display both the fiscal year to date and rolling 12 month performance results in future ECHMN quality reports.	Ute Burness	2/6/2023

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP, RN, NEA-BC, DipACLM
Date: February 6, 2023
Subject: Patient Experience feedback from Press Ganey Survey Comments

Purpose: To provide the Committee with written patient feedback that is received from the Press Ganey written comments.

Summary:

1. Situation: These comments are from a patient who received a Press Ganey survey following discharge from an outpatient surgical procedure.

2. Authority: To provide insight into one patient's experience and the importance of managing nausea post procedure.

3. Background: This patient provided very helpful feedback regarding post procedure nausea management. We have seen this emerge in our Press Ganey data in the past as well.

4. Assessment: This feedback has been provided in the past as well. Therefore, the team has developed a new nausea management protocol that also includes pre-procedure/post-procedure information on nausea management so the patients know what to expect. In addition, ECH has added another weapon to the nausea prevention arsenal that some patients want to try first before moving to medication---aromatherapy. While this may not work for all patients, we can offer this as a non-medicinal option as a first line in our protocol and move to medication for nausea as needed. The new aromatherapy tool is called "QueaseEASE" and has been used with our cancer patients as well with success. This product was invented by a nurse anesthetist. The team believes that offering more than just medication (and something we can send home since it is over the counter) is a great option for patients. However, as part of the protocol, we can offer medications first, especially if the patient knows what works for them based on past personal experience. Anesthesia has worked closely with nursing to create the new protocol.

5. Other Reviews: None

6. Outcomes: We will continue to monitor our comments and our Press Ganey scores as we have implemented our new post-op nausea strategy/protocol/patient education.

List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. How do you prioritize which comments to focus on in your improvement work?

2. How do you apply learnings from this individual issue to the larger organization?

This comment came from our Press Ganey Outpatient Surgery Survey

"Overall great experience. One suggestion would be to give all patients that go under anti-nausea medicine at the end of the procedure. Patients should not have to wait to see if they get sick or not."

El Camino Health

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

To: Quality, Patient Care and Patient Experience Committee
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: February 6, 2023
Subject: FY23 Second Quarter Board Quality Dashboard (STEEEP)

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety and experience metrics and performance through Quarter 2 of FY 2023 (unless otherwise noted).

Summary:

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

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

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

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

   A. Safe Care—The Hospital Acquired Condition (HAC) metric is a weighted composite of five individual measures. The methodology for this measure is modeled after the CMS 5-Star rating methodology. Second quarter performance is 1.25 (lower is better). HAC Index YTD is at 1.01, which is within 5% of target of 0.986.

   Below is a table with baseline HAC Index values from final FY22.

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

ECH FY23 HAC Index STEEEP Data Legend

Month to Quality Committee of the Board: February, 2023

El Camino Health

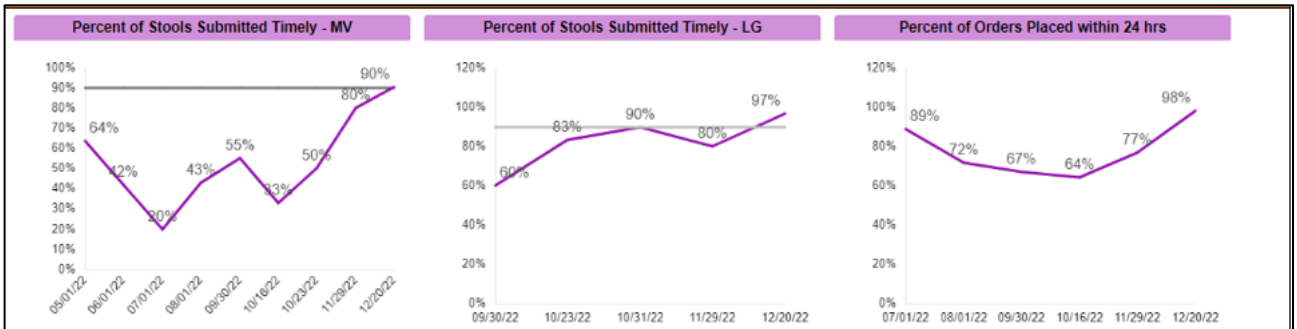
FY23 Quarterly Board Quality Dashboard (STEEEP)

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

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

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

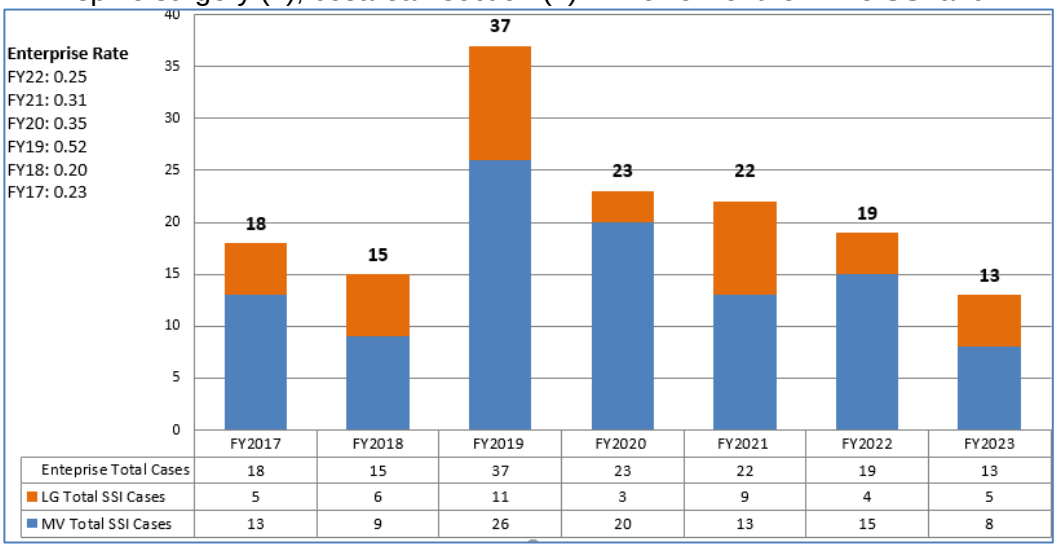
i. C Difficile Infection—Twenty ECH patients have acquired C. Difficile infection since July 2022. Our FY23 target is to have <= 34 C. Diff infections. In the first 2 quarters of FY23. Of these 20 infections, 5 patients likely had C. Diff on admission but stool collection to confirm diagnosis was not performed timely (prior to 3rd midnight of patient's hospitalization) and so these 5 patients' C. Diff infections are considered hospital acquired for reporting and measurement purposes. Fifteen patients 'truly' acquired C. Diff infection during their ECH hospitalization.
   1. Process Improvement efforts are focused on two broad opportunities; timely screening & testing of at risk & symptomatic patients, and, environmental hygiene to avoid nosocomial spread.
   2. Timely stool collection from patients with C. Diff symptoms has improved significantly since roll out of new 'standard procedure' in October 2022.



After the new policy was implemented and educated to, the team saw a huge increase in our 3 key measures and all 3 measures met target in December.

3. Our policy and protocols for hand hygiene, personal protective equipment, and disposable supplies in isolation rooms are not being followed consistently. Focus and a call to action with detailed education, monitoring and improvement plans are in process for all three of these important practices.
4. Please see attachment 2, C. Diff A3.

ii. Surgical Site Infection (SSI)—The target for SSI in FY23 is to have <=17 surgical site infections. Year to date we have had 13 surgical site infections through December 2022. During this fiscal year there is a concerning increase in # of surgical site infections on our Los Gatos campus (5). There were 4 SSI in Los Gatos in FY22. The breakdown by type of surgery is; colon surgery (3), hysterectomy (3), knee surgery (3), cholecystectomy (1), spine surgery (2), cesarean section (1). A review of the FY23 SSI and FY22



	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023
Enteprise Total Cases	18	15	37	23	22	19	13
LG Total SSI Cases	5	6	11	3	9	4	5
MV Total SSI Cases	13	9	26	20	13	15	8

SSI has not revealed any trends or themes as to possible root causes of the infection. Management is in the process of trending infections going back 5 years to see if there are any surgeon specific patterns. Current focus is addressing three 'general' opportunities to decrease surgical site infections;

1. Improve compliance with Enhanced Recovery after Surgery (ERAS) elements.
2. Using a clean tray, surgical gown and gloves to 'close' the incisions for appropriate surgical cases.
3. Enforce adherence to pre-surgical hair clipping procedure, so that hair clipping is completed in the pre-op area, not in the operating room.

iii. Non-ventilator Hospital Acquired Pneumonia-The number of patients developing pneumonia per quarter is 28.5, above our target of 26.59 per quarter. Key drivers of the above desired incidence of pneumonia are due to a lack of compliance with the bundle of interventions to decrease the risk of pneumonia. Management is focused on increasing compliance with oral care (4x per day for patients) and ensuring patients are sitting up in a chair for meals, and, that the head of the hospital bed is elevated. Please see attachment 3, nvHAP A3.

iv. Falls—We are not meeting the FY23 target of having < 35 patient falls per quarter. Year to date, there are 37.5 falls per quarter on our inpatient floors/units. In addition to monitoring compliance with hourly patient rounds, (which has been shown to decrease falls), management is rolling out an enterprise-wide mobility initiative, championed by the medical director of Rehab, Dr. Meagan Littlepage. nvPneumonia, falls, pressures injuries are all impacted by our patient's mobility. The less our patients walk/move, the greater their risk of developing these hospital acquired conditions. Rolling out the Hopkins Mobility program will help ECH toe the fine line between increasing mobility to decrease falls. "Our current system of "keeping score" of falls has created a strong disincentive for mobilizing patients…Promoting mobility in the hospital while preventing falls aligns well with the broader healthcare missions of maintaining quality, decreasing costs, and enhancing patient-centered care". (Growdon, 2017)

v. Hospital Acquired Pressure Injury (HAPI)—In FY22 we had 8 hospital acquired pressure injuries. Our performance FY23 is similar to FY22, not improved. Four ECH patients have had stage 3 or 4 pressure injuries YTD through November. There were no pressure injuries in December 2022. Current state assessment of HAPI prevention workflows reveals a gap in nursing training during new hire orientation. When orientation was transitioned from in person to virtual due to the pandemic, HAPI education was removed from general orientation and skills day. The gap in training (new and refresher) is being addressed with deployment of a 5 week "HAC-a-Thon" lead by our education team. There will be hands on skills training, and education on each of the 5 HAC measures, including, HAPI prevention. Kick off the HAC-a-thon is planned for February 2023.

B. Timely Care

i. ED Imaging Turnaround Time. The FY23 enterprise target for imaging turnaround time in the ED is to have 84% of studies completed and read within 45 minutes. Current performance is not meeting target (78.3%) through November 2022. Drivers of the current performance are 1. Difficulty recruiting radiologists to join team, 2. The third party performing our night reads has had technical and staffing issues. 3. The complexity of radiology call coverage at night created a barrier for teams to escalate long reading times and know who in radiology to call to get a study read timely in the middle of the night. Improvement efforts are focused on 1. Leveraging technology to expand reading capability to radiologists who are remote from California. 2. & 3. Have clear escalation process and on-call schedule in "Amion" the platform used hospital wide for other service departments' call schedules. Our ECH radiologists are proactive and engaged in improving performance.

C. Effective

i. Risk Adjusted Readmission Index. Readmission Index for the month of November is 0.96, below (favorable) to our target of 1.00. YTD our index through November is 1.04. The readmission steering team is encouraged by the progress in decreasing readmissions for Sepsis patients through

collaboration and partnership with our Skilled Nursing Facilities (SNFs). Our sepsis coordinator has been to each of our 11 partner SNFs to provide education, tools, and build relationships with the SNF staff to optimize collaboration between acute and post-acute settings. We are replicating this model for heart failure and oncology patients. As our census of COVID patients decreases, we anticipate a favorable impact on our overall readmission rate after having learned in FY22 that COVID patients are readmitted 26% of the time.

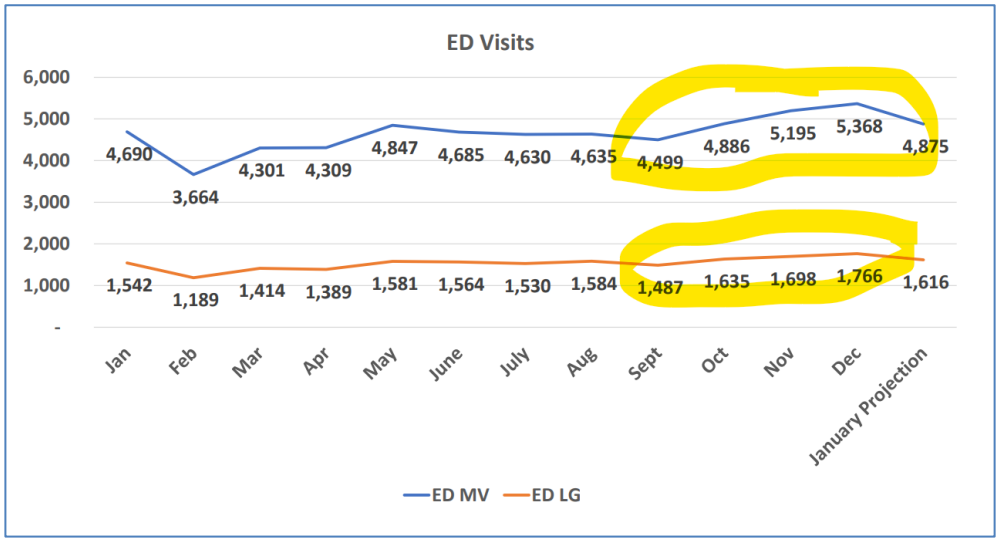
ii. Risk Adjusted Mortality Index. The risk adjusted mortality index for Q2 (1.07) is unfavorable to the target of 0.85. This unfavorable increase is attributed to sepsis mortality. 46% of the patients who died in November had sepsis. The next leading 'cause' of death was respiratory (24%).

iii. Sepsis Mortality Index. FYTD Sepsis Mortality Index for Q2 (1.26) exceeded the FY23 target of 0.98. A drop in compliance with completion of the 3-hour sepsis bundle in MV decreased concomitant with the increase in sepsis mortality. The Emergency Dept leadership team has gone through a transition due to the passing of Dr. Cook, the previous Medical Director. Duties for improvement work in the ED are divided amongst several physicians. Quality and sepsis team looks to partner with the newly identified ED sepsis champion, Dr. Linker to understand why compliance with the sepsis bundle has declined, and, how we can support improvement efforts.

iv. NTSV C-section Rate for Primigravid Woman with a singleton pregnancy will be finalized on Feb 1, 2023 for Q1 of 2023.

D. Efficient

i. OP18b: Median Time from ED Arrival to ED Departure—The Q2 performance of 169 minutes is a favorable improvement from 176 minutes in first quarter. In the setting of peak ED census in Q2, the team is encouraged



by this progress. The Process Improvement team is deployed to the ED to complete value stream process walks to identify efficiency opportunities. This work began in January 2023. The intervention of having four additional treatment areas 'chairs' to use for patients appropriate for 'Treat to Street' evaluation and treatment. Having a dedicated space for this population of ED patients will favorably affect ED throughput. The lower acuity patients will be channeled into this more efficient route to being seen and treated timely.

E. Patient Centered

i. IP Units –HCAHPS Likelihood to commend. Inpatient units did not meet target. FY23 Q2 performance is 78.8 < target of 81. However, there was improvement from Q1. Los Gatos was not at target the previous month but due to increased effort on nurse leader rounding, bedside shift report and purposeful rounding (known as the Power of 3), Los Gatos did achieve target this month. Los Gatos is also at target for FYTD. In our Mountain View campus, 3B increased substantially due to an increased focus on nurse leader rounding, nurse communication (key drivers) and WeCare behaviors. We will continue to spread and sustain these best practices.

ii. ED Likelihood to Recommend Top Box Rating. We did not meet our target for Q2 of FY23. FYQ2 performance of 72.3 < target of 75.0. Improvement in LTR and our key driver of staff worked together improved from prior quarter. We continue to have high census and acuity which impacts wait times. Only patients admitted to inpatient from the ED receive the survey for their ED experience. For those patients waiting greater than four hours, scores decline substantially. We are working on a plan to discharge lower acuity patients more efficiently. The new ED Navigator has started and is helping with communication about wait times and other customer service issues that arise.

iii. MCH – HCAHPS Likelihood to Recommend. FY23 Q2 performance is lower than goal of 81.5. The drivers of low satisfaction for our MCH patients are unchanged from Q1. These are construction noise, and visitor and family issues related to COVID restrictions. The recent change in our visitor policy helped. As the census increases, there was more patient movement, which resulted in dissatisfied patients and families.

iv. ECHMN Likelihood to Recommend Care Provider. We did not meet our target for Q2. FY23 Q2 performance of 81.6 < target of 83.4. Primary care and urgent care performance improved from Q1.

List of Attachments

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

Attachment 2—C.Diff A3

Attachment 3—nvHAP A3

Bibliography

Growdon, M. S. (2017). The Tension Between Promoting Mobility and Preventing Falls in the Hospital. *JAMA Internal Medicine*, 759-760.

Month to Quality Committee of the Board: February, 2023

El Camino Health

FY23 Quarterly Board Quality Dashboard (STEEEP)

Quality Domain	Metric	Past Performance				Baseline	Target	Current Performance				
		FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY 22	FY 23	FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	FYTD
Safe Care	HAC Index	1.05	1.3	1.6	0.86	1.066	**0.986**	0.80	1.25			**1.01**
	HAC Component: Clostridium Difficile Infection (C.diff)	8	8	7	14	9.25	**8.56**	7	13			**10.0**
	HAC Component: Surgical Site Infections (SSI)	5	4	7	2	4.5	**4.16**	6	7			**6.5**
	HAC Component: nvHAP	36	29	26	24	28.75	**26.59**	26	31			**28.5**
	HAC Component: IP Units area Patient Falls Reported to NDNQI	26	48	47	32	38.25	**35.38**	25	50			**37.5**
	HAC Component: HAPI Stage 3, Stage 4 and Unstageable	0	3	3	2	2.00	**1.85**	2	2			**2.0**
Timely	Stroke: TTITT (time to intravenous thrombolytic therapy) <= 30 min	25% (1/4)	10% (1/10)	75.0% (6/8)	0% (0/6)	28.6% (8/28)	**50%**	50% (4/8)	71.4% (5/7)			**60% (9/15)**
	Stroke: Door-to-Groin <= 90 minutes	50% (1/2)	28.6% (2/7)	50% (1/2)	25% (1/4)	33.3% (5/15)	**50%**	100% (2/2)	75.0% (3/4)			**83% (5/6)**
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)	80.35%	79.68%	82.26%	74.14%	79.01%	**84%**	78.43%	78.34%			**78.38%**
Effective	Risk Adjusted Readmissions Index	1.05	0.96	1.12	1.06	1.05	**1.00**	1.02	1.04			**1.03**
	Risk Adjusted Mortality Index	0.99	0.92	0.99	0.85	0.94	**0.85**	1.03	1.07			**1.05**
	Risk Adjusted Sepsis Mortality Index	1.07	1.01	1.10	0.91	1.02	**0.98**	1.02	1.26			**1.14**
	PC-02 NTSV C-Section	25.8%	25.0%	24.1%	28.3%	25.80%	**23.5%**	---	---	---	---	---
Efficient	OP18b: Median Time from ED Arrival to ED Departure (Enterprise)	160 min	156 min	162 min	169 min	162 min	**162 min**	176 min	169 min			**170 min**
Equitable	% Patients - Ethnicity documented	98.1%	97.9%	97.8%	97.8%	97.9%	----	97.6%	97.0%			**97.3%**
	% Patients - Race documented	98.6%	98.5%	98.0%	98.1%	98.3%	----	97.8%	97.3%			**97.6%**
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	82.0	80.2	81.5	79.4	80.8	**81**	79.9	78.8			**79.4**
	ED - Likelihood to Recommend (PG)	73.1	75.8	77.4	71.5	74.5	**75**	70.3	72.3			**71.3**
	MCH - HCAHPS Likelihood to Recommend	79.4	81.0	82.1	82.8	81.3	**81.5**	72.3	71.1			**71.8**
	ECHMN (El Camino Health Medical Network)	---	---	83.6	82.8	83.2	**83.4**	81.1	81.6			**81.4**

Updated: 1/18/23

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

Legend:

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

El Camino Health

Created: 9/6/2022

Reducing C. Diff for FY23

Last Updated: 1/23/2023

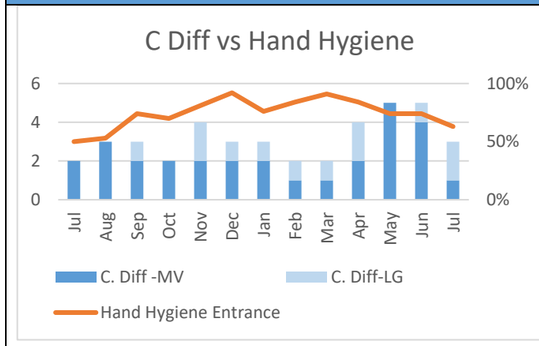
F-IND A PROBLEM

Clostridium Difficile (C. Diff) is bacterial infection of the large intestines. Rates of hospital acquired C. Diff infections are frequently measured as a quality standard for hospitals in the USA. In FY22 at El Camino Health Hospital (ECH), C. Diff. doubled from previous years (15 cases to 37 cases). C.diff is a part of ECH's HAC index and makes up 10% of the index. In order to meet ECH's high quality standards and provide the best care to our patients the quality department has set a goal of reducing C. Diff rates by 7.5% in FY23 from 37 cases to 34 cases.

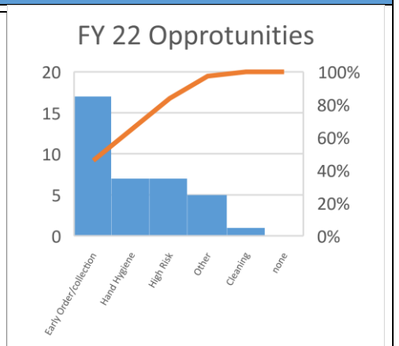
O-RGANZIE A TEAM

Name	Role	Name	Role
Holly Beeman	Exec. Sponsor/ CQO	Areena Chaudhry	Manager of Nursing
Lyn Garrett	Sponsor/ Director of Quality	Catherine Nalesnik	Director of Infection Prevention
Jen Murray	Coach/ PI Program Manager	Owen Simwale	Infection Prevention Manager
Ann Aquino	Director of Nursing	Carol Kemper	Med Director Infxn Prevention

C-LARIFY CURRENT CONDITIONS

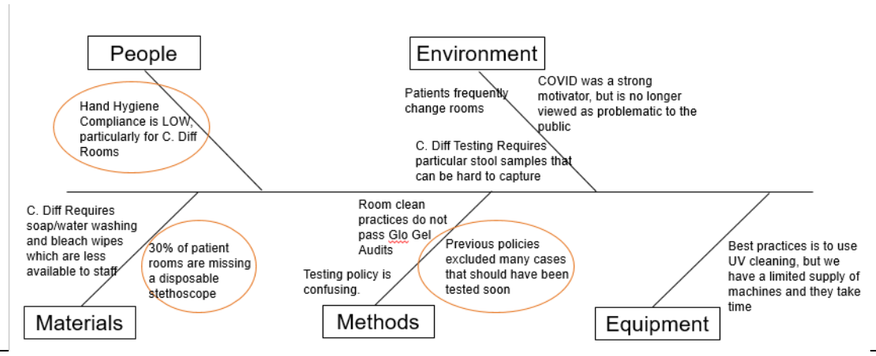


Hand Hygiene upon entering patient rooms has been declining over the last 6 months. And in turn C. Diff Cases have been rising.



U-NDERSTAND ROOT CAUSES

An analysis of FY22 C. diff cases found that 12/38 of a cases were probable for present on admission. This cases could have been counted as community acquired is testing was either ordered or collected sooner. This is was identified to be the biggest gap
Interviews with nursing leaders and staff and policy reviews by IP found that our current testing procedure limited the ability of nurses to test quickly and effectively. Other identified barriers included access to isolation supplies like bleach wipes and disposable stethoscopes and low hand hygiene.



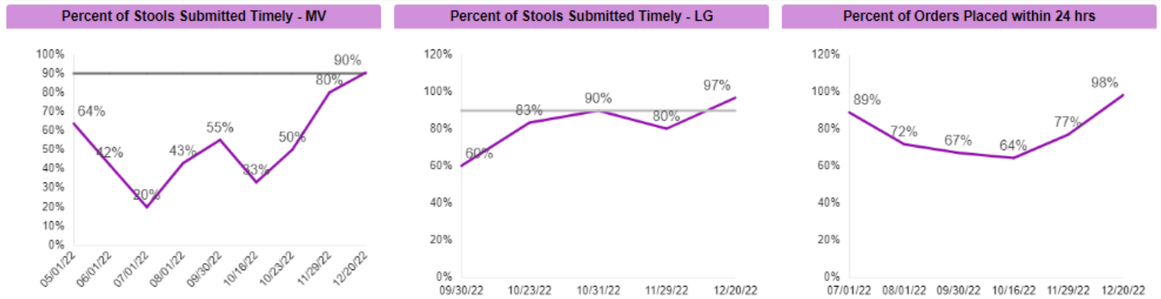
S-ELECT A SOLUTION

Our hypothesis: If we remove exclusion criteria from our policy, and encourage nursing staff to ordering testing after 1 loose stool, then we will see an increase in orders placed and collected timely. This should in turn lead to a decrease in Hospital acquired C.Diff cases.

P-LAN

	Summer	Sept	Oct	Nov	Dec	Jan
Update new Standard Procedure						
New Procedure go live						
Real time education and rounding by IP						
Presentations to managers on how to support new policy						

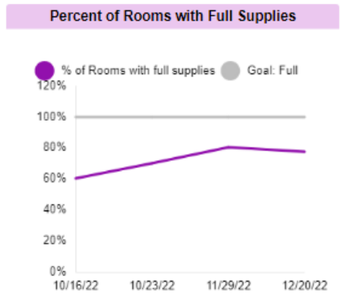
D-O



After the new policy was implemented and educated to, the team saw a huge increase in our 3 key measures and all 3 measures met target in December.

C-HECK

While the team has found great success in increase their 3 key measures regarding early detection in December, they did not see a significant decrease in C. Diff cases. In December ¾ cases would not have been prevented by this countermeasures.



While the team was implementing the new policy, they noticed opportunities in the use of our isolation materials. Only 77% of C. Diff rooms contained all required materials to prevent C. Diff Spread.

A-CT

Early Detection

The team will continue to monitor and communicate our new standard policy to keep compliance high

Spread Prevention

Moving forwards the team wants to focus on tactics to reduce C. Diff spread in our hospital. This will include hand hygiene campaign and improving our isolation precautions and materials

El Camino Health

Created: 9/8/2022

Reducing nvHAP for FY

Last Updated: 1/24/2023

F-IND A PROBLEM

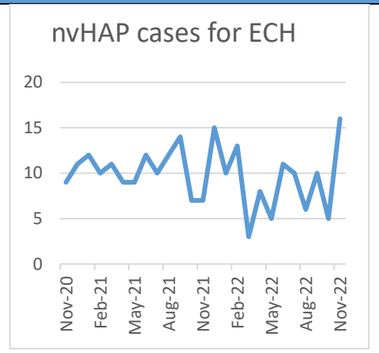
Pneumonia is an infection of the lungs. Rates of non-ventilator hospital acquired pneumonia (nvHAP) infections are frequently measured as a quality standard for hospitals in the USA. In FY23, El Camino health created the “Hospital Acquired Conditions” (HAC) index as a measure of overall quality and nvHAP make up 20% of this measure. This year ECH has a goal of reducing nvHAP from 115 to 106 cases.

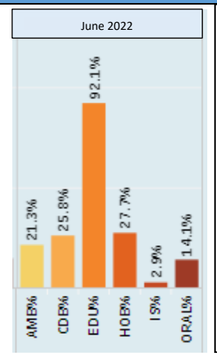
O-RGANZIE A TEAM

Name	Role	Name	Role
Holly Beeman	Exec Sponsor/ CQO	Corneliu Delogramatic	Dir. Clinical Doc
Lyn Garrett	Sponsor/ Dir. Quality	Jennifer Murray	Coach/PI Program Manager
Theresa Legion	Manager of Quality	Molly Cyr	Team Lead/ Manager. Nursing
See Charter	nvHAP unit Champions		

C-LARIFY CURRENT CONDITIONS

In the last year, rates of nvHAP have been less consistent. Although there has been a slight downwards trend, November had the highest volume in the last 2 years. The organization implemented ICOUGH but compliance is very low.

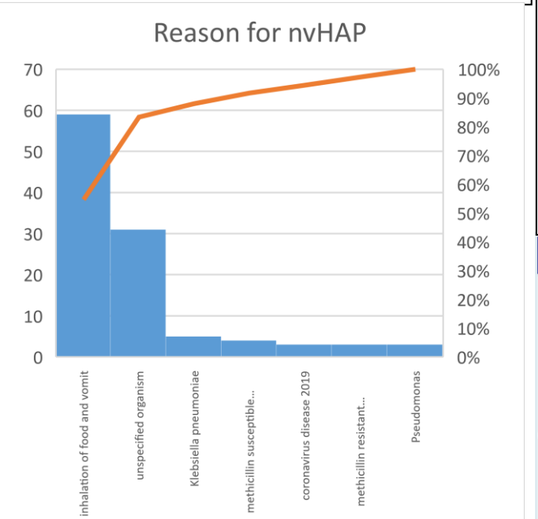




There is currently a workgroup focused on nvHAP. This group is responsible for reviewing nvHAP cases and determining solutions. In the past they have focused on unit specific goals for ICOUGH documentation.

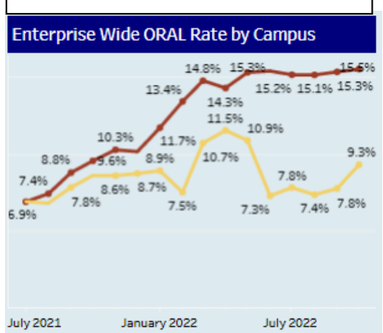
U-NDERSTAND ROOT CAUSES

Most cases (50%) are caused by inhalation of vomit or food.



Conversation with local experts recommend focusing on Oral care and Out of Bed for meals.

Oral Care rates have increased slowly over the years but have plateaued at 15%



BARRIERS

1) Education: Survey’s found that some nurses and patients are uneducated on ICOUGH
2) Documentation: ICOUGH is not bundled in Epic which prevents easy documentation and leads to missed steps
3) Many units are missing key supplies

S-ELECT A SOLUTION

Increase Oral Care Compliance to decrease the risk of Hospital Acquired Pneumonia

Documentation

Create an ICOUGH flow sheet with discrete fields to better capture data

Knowledge

Creating Educational materials for staff and patients

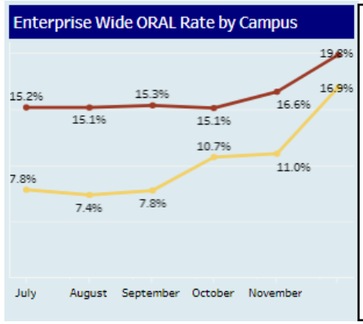
Equipment

Standardize Oral Equipment in all patient rooms

P-LAN

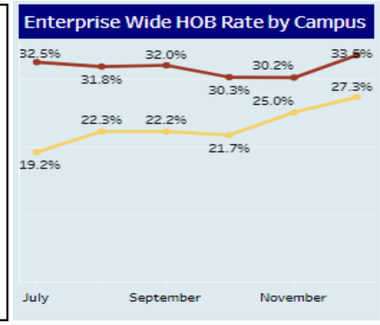
	Summer	Sept	Oct	Nov	Dec	Jan
Equipment: Order Standard Equipment						
Knowledge: Create materials						
Knowledge: Roll out materials						
Documentation: Roll out flow sheet.						

D-O



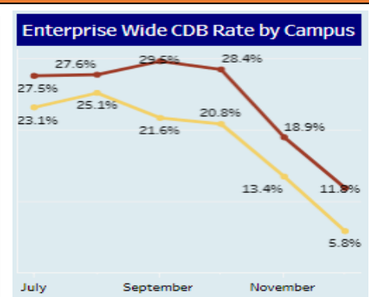
After the roll out of the ICOUGH flowsheet we saw an increase in Head of Bed and Oral Care Compliance. The team is hopeful that the new educational materials will keep this trend moving upwards.

Positive reinforcement to staff through monthly recognition of units based on monthly ICOUGH clinical data



C-HECK

While the team saw early signs of success for Oral care, we also saw a decrease for “Cough and Deep Breaths” measures. While this is not a key measure selected by the team, the team recommends starting a new A3 to investigate these barriers further.



A-CT

El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Shahab Dadjou, President, El Camino Health Medical Network, and Ute Burness, RN, VP of Quality, El Camino Health Medical Network
Date: February 6, 2023
Subject: El Camino Health Medical Network Quarterly Quality Report

Purpose: Provide the Board Quality Committee with a quarterly update on the status of El Camino Health Medical Network quality.

Summary:

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

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

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

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

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

   ECHMN has established true north pillars, two of which is quality and service. Starting June 1, 2023, ECHMN changed to a new way to report quality. The new methodology measures the performance of PCP attributed patients on six (6) clinical indicators. These measures were selected because they are important measures of health and consistent with the priorities of our health plan partners and with CMS. ECHMN tracks the performance to targets. We have met targets for two (2) clinical measures and are close to meeting targets on the remaining four (4). For dependable and convenient, we are not meeting target for Third Next Available (3NA) and we have a work plan for improvement.

   Likelihood to Recommend (LTR) is close to target for the primary care physicians. We are working on an improvement plan for specialty and urgent care.

   MIPS is a calendar year measure. We submit our data for the calendar year no later than March 30, 2023. Centers for Medicare and Medical (CMS) publishes the MIPS score in the fall of 2023.

List of Attachments:

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

Suggested Committee Discussion Questions:

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

El Camino Health

ECH Quality Committee Meeting
ECHMN Quality Update

February 6, 2023

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

Agenda

- Quality Infrastructure Enhancements
- Dashboard Review
- Relevant Explanation and Work Plan

Quality Infrastructure Enhancements

1. Reconstituted Quality Committee

- Expand membership to include representation from PCP and Specialties

Committee Member	Representation
Jaideep Iyengar, MD (Co-Chair)	Orthopedic Surgery
Ute Burness, RN (Co-Chair)	Vice President of Quality, ECHMN
Archana Bindra, MD	Endocrinology
Katrina Chaung, MD	ENT
Maria Govorkova, MD	Ophthalmology
Rowena Murthy, MD	PCP
Richard Ornelas, MD	PCP
Saigeetha Sundaramurthy, MD	Rheumatologist
Shabnam Husain, MD	PCP
Shane Dormady, MD	Oncologist
Noel Bell, PA	Physician Assistant (Primary Care)
Raabia Ahmad, MD	Cardiologist
Sheetal Ankolekar, MD	Urgent Care
Holly Beeman, MD	Chief Quality Officer, ECH
Shahab Dadjou	President, ECHMN
Nicole Silva	COO, ECHMN
Fariba Shahbazi, RN	Director of Operations, ECHMN
Mandeep Khabra, MD	Physician Consultant
Teresa Timbreza	Director of Operations, ECHMN
Carla Abalos, RN	Quality Improvement Nurse, ECHMN

Quality Infrastructure Enhancements

2. Formalized Committee Charter

- Balance of primary, medical and surgical specialties
- Defined roles and responsibilities
- Annual work plan including metrics
- Quarterly review of metrics and corrective action plan
- Periodic reports to the Board

3. Augmented Technology for Data Capture and Reporting

- Address care gap issues (i.e. Blood Pressure Control)

4. Successfully Recruited and On-boarded Quality Nurse

- Carla Abalos, RN, BSN started in October 2022
- Over 8 years experience working as a Quality RN in a large healthcare delivery system and health plan
- Primary responsibilities:
  - Development and measurement of quality improvement programs
  - Partner with the health plans and providers
  - Perform medical chart reviews
  - Monitor and evaluate provider compliance with quality metrics
  - Review complaints and grievances

Dashboard Review

FYTD 23 Performance (7/22-12/31/22) for Clinical Excellence

Domain	Measure	Baseline FY22	FY23 Target	FYTD 23	Findings
Clinical Excellence	Blood Pressure Management - primary care only	60%	65%	50%	Close to Target
	Diabetes Management-HbA1C <9% - primary care only	24%	<20%	27%	Close to Target
	Breast Cancer Screening - primary care only	68%	69%	74%	Above Target
	Colon Cancer Screening - primary care only	57%	61%	66%	Above Target
	Annual Flu Vaccination - primary care only	70%	71%	60%	Close to Target
	Medication Reconciliation - primary care only	98%	98.40%	94%	Close to Target

Work Plan For Clinical Excellence Domain

Measure	Explanation	Action Plan	Timeline
Blood Pressure Control	• Is a calendar year measure • Second blood pressure is not consistently taken	• Take second blood pressure before end of visit • Investigate and implement remote monitoring • Setup Blood Pressure Clinics	June 2023
Diabetes HBA1c	• On track with the measure • One HBA1C test required in a calendar year	• Send diabetic patient list to office managers and physicians • Follow-up with patients that are non-compliant with completing the lab test • Send reminder messages to diabetic patients about getting their annual HBA1C test	June 2023

FYTD 23 Performance (7/22-12/31/22) for Dependable, Convenient and Experience Domain

Domain	Measure	Baseline FY22	FY23 Target	FYTD 23
Dependable and Convenient	Access 3na for primary care	18.1 days	13.5 days	19.4 days
	Access 3na for specialty care	20.4 days	15.3 days	23.9 days
	Patient enrollment in my chart	63%	63%	67%
	Clinician response to patient message < 48 hours?	1.48 days	1.2 days	1.2 days
Experience	Primary Care LTR	83.2%	84.8%	81.8
	Specialty Care LTR	86.8%	87.9%	82.8
	Urgent Care LTR	78%	80.7%	74.5

Work Plan for Dependable and Convenient Domain

- Third Next Available (3NA)
  - Amended provider schedules to increase access

- Clinical Response to Patient Messages
  - Piloting RN triage at one site

Work Plan for Patient Experience Domain

- Provide more appointments by recruiting more providers (PCP)
- Provider and staff training (WeCare)
- One on one provider sessions to review patient experience data and plan for improvement
- Real time data capabilities
- Internal benchmarking among each specialty

Questions

El Camino Health