El Camino Health

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

Monday, April 3, 2023 – 5:30 pm
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 916 7656 6238#. 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 – 5:32 pm**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Carol Somersille, MD Quality Committee Chair	*public comment*	**possible motion 5:32 – 5:33**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair		**information 5:33 – 5:34**
4.	**PUBLIC COMMUNICATION**	Carol Somersille, MD Quality Committee Chair		**information 5:34 – 5:37**
5.	**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 – 5:52**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (03/06/2023) ***Information*** b. Report on Board Actions c. Value Based Purchasing Report d. FY23 Enterprise Quality Dashboard e. QC Follow-Up Items			
6.	**CHAIR'S REPORT**	Carol Somersille, MD Quality Committee Chair		**information 5:52 – 5:57**
7.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer		**discussion 5:57 – 6:07**
8.	**REVIEW & APPROVE FY24 COMMITTEE PLANNING ITEMS** a. FY24 Committee Goals b. QC Charter c. FY24 Pacing Plan d. FY24 QC Dates	Holly Beeman, MD, MBA, Chief Quality Officer	*public comment*	**motion required 6:07 – 6:37**

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
9.	**PROPOSED FY24 ENTERPRISE ORGANIZATIONAL GOALS**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:37 – 6:47**
10.	**ADJOURN TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 6:47 – 6:48**
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair		**information 6:48 – 6:49**
12.	**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 (03/06/2023) ***Information*** *Health and Safety Code Section 32155* b. Quality Council Minutes (03/01/2023)	Carol Somersille, MD Quality Committee Chair		**motion required 6:49 – 6:54**
13.	*Health and Safety Code Section 32155* **CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer		**motion required 6:54 – 7:04**
14.	*Health and Safety Code Section 32155* **SERIOUS SAFETY/RED ALERT EVENT**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 7:04 – 7:09**
15.	**ADJOURN TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair		**motion required 7:09 - 7:10**
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 7:10 – 7:11**
17.	**ROUNDTABLE**	Carol Somersille, MD Quality Committee Chair		**discussion 7:11 – 7:14**
18.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 7:14– 7:15 pm**

Next Meeting: May 1, 2023, June 5, 2023

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, March 6, 2023
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Pancho Chang**
Philip Ho, MD
Prithvi Legha, MD
Jack Po, MD
Krutica Sharma, MD
Melora Simon
John Zoglin

Members Absent
Carol Somersille, MD

Others Present
Dan Woods, CEO**
Meenesh Bhimani, MD, COO
Mark Adams, MD, CMO
Deb Muro, CIO**
Shreyas Mallur, MD, ACMO
Shahram Gholami, MD**
Lyn Garrett, Senior Director, Quality
Daniel Shih, MD**
Tracy Fowler, Director, Governance Services
Nicole Hartley, Executive Assistant II

**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 5:34 pm by Vice Chair Melora Simon. A verbal roll call was taken. Dr. Sharma joined at 5:36 pm, Dr. Ho joined at 5:51 pm, and Dr. Legha joined at 6:23 pm. Dr. Somersille was absent. All other members were present at roll call and participated in-person or telephonically. A quorum was present.	
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	Ms. Hartley shared that we have one member of the Committee, Pancho Chang participating remotely due to Just Cause. Vice Chair Simon ask Mr. Chang if there were any adults in the room. Mr. Chang confirmed there were not.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Vice Chair Simon asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
4. PUBLIC COMMUNICATION	There were no comments from the public.	

5. CONSENT CALENDAR	Vice Chair Simon asked if any Committee member would like to pull an item from the consent calendar. No items were pulled. **Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (02/06/2023); For information: (b) Report on Board Actions, (c) Progress against FY 2023 Committee Goals, (d) QC Follow-Up Items **Movant**: Zoglin **Second**: Po **Ayes**: Chang, Po, Simon, Sharma, Zoglin **Noes**: None **Abstain**: None **Absent**: Ho, Legha, Somersille **Recused**: None	***Consent Calendar Approved***
6. CHAIR'S REPORT	Vice Chair Simon welcomed Pancho Chang to the Committee and asked Dr. Po to report out from the February 15, 2023 Hospital Board Meeting regarding Quality Metrics. Dr. Po gave an overview of the Patient Experience report out that was shared at the board. He shared that more detailed information was given on the challenges to the HAC Index and that as requested from the last Quality Committee meeting, a timeline of expected improvement was shared.	
7. PATIENT STORY	Dr. Meenesh Bhimani, COO presented the Patient Story. The comment is from a patient who received a Press Ganey survey following treatment and discharge from the emergency department. The patient expressed that the staff was nice but there were no private beds or rooms and their care was completed in a hallway chair. There has been a 30% increase in ED patient volumes and this story highlights the struggle with space constraints. Due to a lack of privacy and patient concerns, the staff came forward with an idea to convert some office space to patient care space adding 4 additional recliner chairs for low acuity patients. These chairs were activated in January and are able to provide additional privacy while also promoting a timely turnaround in triage, care, treatment and discharge. Dr. Bhimani shared that the ED throughput measure did hit target in January and there are other improvement trends showing. Vice Chair Simon asked if we could answer the proposed questions listed on the memo. Dr. Adams commented that this is an intermediate solution and it is better to treat the patient than have them in the waiting room. Mr. Zoglin asked about global care comparison. A discussion occurred about Global care versus care expectations in the	

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	US. The discussion highlighted the importance of setting proper expectations for patients and what they will expect for their treatment. Dr. Po asked about potential alternatives to patients waiting and the committee discussed ideas. Dr. Bhimani shared that we can look into other options to see what other systems are doing effectively. Vice Chair Simon suggested that on the website where ED wait time is posted, could we post alternative locations for patients to choose from. Additionally, having guidance on when to utilize the emergency department versus Urgent Care. Vice Chair Simon requested for a future meeting that we have a deep dive into the emergency department times and throughput and what is causing the backups.	***ACTION:*** *Deep Dive on emergency department times and throughput at a future meeting.*
8. FY23 ENTERPRISE QUALITY DASHBOARD	Dr. Mark Adams, CMO presented the FY23 Enterprise Quality Dashboard. He shared some professional insight on surgical site infections (SSI). When analyzing SSIs, they look for patterns in a variety of factors: rooms, surgeons, instruments, bacteria, etc. In review of the SSI's, no trends are apparent and the infections appear sporadic. There is often a physiologic delay in the manifestation of a surgical site infection. For some times of surgeries, we need to wait for 90 days post-surgery to determine if an infection has developed after surgery. Most show up in the first month but not in the first week because it is often suppressed by antibiotics. There was discussion about the PC-02: Cesarean Birth Core Measure that focused on this target being set by CA not ECH, the demographics in our district that drive higher rates (age of mother and diabetes), and doctors with high percentages being flagged in the credentialing process.	
9. PROPOSED FY24 COMMITTEE PLANNING ITEMS	Dr. Mark Adams, CMO opened the discussion for the Proposed FY24 Committee Planning Items to the committee. **FY24 Committee Goals:** Mr. Zoglin asked the committee if item number 4: *All committee members regularly attend and are engaged in committee meeting preparation and discussions* need to be a listed goal. Can we build on Dr. Somersille's comments of having additional education on Patient Experience as one of our goals? Dr. Adams shared we will consider that recommendation. Vice Chair Simon asked the committee if we should add a goal around how we treat each other. Mr. Woods asked if the behavior question is for the Enterprise/all Committees or would each Committee have its own behavior goals. Ms. Fowler responded by sharing we are the first committee to discuss this and will look into this. Dr. Po asked if we could bring this topic for discussion at the Governance Committee.	

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	QC Charter: Mr. Zoglin suggested that if the Charter focuses on whole system quality, the Committee Goals should reflect that as well. Vice Chair Simon agreed. Dr. Adams agreed that both should align. Additionally, the charter should be a high-level document and these changes add quite a bit of detail. Dr. Adams shared that governing behavior through a charter is difficult to measure. Vice Chair Simon shared that with the Specific Duties in the charter, we are great with quality control but not quality planning. Dr. Adams and Lyn Garrett shared that the Quality Improvement and Patient Safety Plan (QAPI) is the quality planning the committee sees. **FY24 Pacing Plan:** Vice Chair Simon noted that the Culture of Safety Survey was not listed on the Pacing Plan and to please include it for FY24. Dr. Adams shared we can add it. **FY24 QC Dates:** Dr. Adams shared that if the dates move, Credentialing and Privileges would not align and would need to go straight to the hospital board. After discussion, the recommendation is to keep the meetings on the first Monday.	
10. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 6:46 pm. **Movant**: Po **Second**: Sharma **Ayes**: Chang, Ho, Po, Legha, Simon, Sharma, Zoglin **Noes**: None **Abstain**: None **Absent**: Somersille **Recused**: None	***Adjourned to closed session at 6:46 pm***
11. AGENDA ITEM 16: RECONVENE OPEN SESSION/REPORT OUT	The open session reconvened at 7:13 pm. Agenda items 11-15 were addressed in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (02/06/2023), the Medical Staff Bylaw revisions, the Quality Council Minutes (02/01/2023), and the Credentialing and Privileges Report by unanimous vote by all committee members present.	
12. AGENDA ITEM 17: ROUNDTABLE	No additional comments.	
13. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 7:14 pm **Movant**: Po **Second**: Sharma **Ayes**: Chang, Ho, Po, Legha, Simon, Sharma, Zoglin **Noes**: None **Abstain**: None **Absent**: Somersille	***Adjourned at 7:14 pm***

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	Recused: None	

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

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Nicole Hartley, Executive Assistant, II

Prepared by: Nicole Hartley, Executive Assistant, II
Reviewed by: Tracy Fowler, Director of Governance Services

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EL CAMINO HOSPITAL BOARD OF DIRECTORS
QUALITY COMMITTEE MEETING MEMO

To: Quality Committee
From: Tracy Fowler, Director Governance Services
Date: April 3, 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:

Since the last time we provided this report to the Quality Committee, the Hospital Board met once and the District met once. In addition, since the Board has delegated specific authority to the Executive Compensation Committee, the Compliance and Audit Committee, and the Finance Committee, those approvals are also noted in this report for any meetings since the last Quality Committee

Board/Committee	Meeting Date	Actions (Approvals unless otherwise noted)
ECH Board	March 8, 2023	- Investment Committee Member Appointments
ECHD Board	March 28, 2023	- No approvals to report
Compliance and Audit Committee	No meetings	- No approvals to report
Executive Compensation Committee	March 16, 2023	- No approvals to report
Finance Committee	March 27, 2023	- FY2023 Period 7 Financials
Quality Committee	N/A	- N/A

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: April 3, 2023
Subject: Medicare Value Based Purchasing Program

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on El Camino Health's performance in the CMS Valued Based Purchasing Program for Federal Fiscal Year 2022 and 2023.

Summary:

Situation: CMS is neither penalizing nor rewarding hospitals for the FFY2022 and FFY2023 VBP programs due to the impact of COVID – therefore there is no performance data to review.

" Value Based Purchasing data was impacted by the extraordinary circumstances exception CMS granted for certain reporting requirements for Q1 and Q2 2020 data. Data from Q1 and Q2 2020 were not used in Hospital VBP calculations for FY 2022.
HVBP Exclusion Reason 1: Due to a public health emergency, CMS suppressed several measures: therefore, there is not enough data to award a Total Performance Score"

Background: The Hospital VBP Program rewards acute care hospitals with incentive payments for the quality of care provided in the inpatient hospital setting. This program adjusts payments to hospitals under the Inpatient Prospective Payment System (IPPS) based on the quality of care they deliver. (Centers for Medicare & Medicaid Services, 2023)

The Hospital VBP Program is designed to make:

- The quality of care better for hospital patients.
- Hospital stays a better experience for patients.

The Hospital VBP Program encourages hospitals to improve the quality, efficiency, patient experience and safety of care that Medicare beneficiaries receive during acute care inpatient stays by:

- Eliminating or reducing adverse events (healthcare errors resulting in patient harm).
- Adopting evidence-based care standards and protocols in order to obtain the best outcomes for Medicare patients.
- Incentivizing hospitals to improve patient experience.
- Increasing the transparency of care quality for consumers, clinicians, and others.
- Recognizing hospitals that provide high-quality care at a lower cost to Medicare.

CMS rewards hospitals based on the quality of care provided to Medicare patients, not just the quantity of services provided.

Medicare Value Based Purchasing Program
April 3, 2023

The program:

- Withholds participating hospitals' Medicare payments by a percentage specified by law (2%).
- Uses the estimated total amount of those reductions to fund value-based incentive payments to hospitals based on their performance in the program.
- Applies the net result of the reduction and the incentive as a claim-by-claim adjustment factor to the base operating Medicare severity diagnosis-related group (MS-DRG) payment amount for Medicare fee-for-service claims in the fiscal year associated with the performance period.

Hospitals are scored on measures such as:

- Mortality and complications
- Healthcare-associated infections
- Patient safety
- Patient experience
- Efficiency and cost reduction

Each hospital may earn 2 scores on each measure—one for achievement and one for improvement. The final score awarded to a hospital for each measure is the higher of these 2 scores. We adjust a part of hospitals' Medicare payments based on a total performance score that reflects, on a measure-by-measure basis:

- How well they perform compared to all hospitals, or
- How much they improve their own performance compared to their performance during a prior baseline period.

Bibliography:

Centers for Medicare & Medicaid Services. (2023, March 27). *The Hospital Valued Based Purchasing Program.* Retrieved from CMS.gov: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing

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: April 3, 2023
Subject: Enterprise Quality, Safety and Experience Dashboard through October 2022

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety and experience metrics and performance through February 2023 (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. Assessment:

   A. **Quality Measures**

      i. **Hospital Acquired Condition Index** (lower is better). This metric is a composite of monthly weighted rates of 5 component measures. During February, the index was 0.959 which is lower (favorable) than target of 0.986. Year to date the HAC Index is 0.970 (favorable) the FY23 target of 0.986.

      ii. **Sepsis Mortality Index** (lower is better). The Sepsis Mortality Index control chart FY23 shows common cause variation in February 2023. Year-to-date the sepsis mortality index of 1.16 is unfavorable to the target of 0.98. ECH compliance with sepsis bundle (early administration of antibiotics and aggressive fluid resuscitation) is better for patients identified with Sepsis in the ED than patients identified sepsis on the floor. Our data shows that 60% of sepsis is identified in the ED and the remaining 40% of sepsis is identified on an inpatient unit. Focus of process improvement efforts is to partner with Information Technology team to approve and deploy the artificial intelligence Ambient's Sepsis DART (detection and response tool) application.

      Generally speaking from our ECH Sepsis subject matter experts, the path to improve sepsis care lies in 4 main areas;

      1. Post-sepsis syndrome/post discharge follow up and care (we are leading that work in our county (likely in the state) by having a Sepsis Navigator CNS.

2. Delivering FASTER care. (1 vs 3 hour bundle outcomes? MV ED is currently enrolled in a national study with 17 other sites (AIMS), first of its kind to evaluate the outcome benefits to each bundle timeframe)
3. Labs/diagnostics to predict likelihood of sepsis based on host response/immunology. Research in early phases for this body of work.
4. Artificial intelligence or clinical decision support needed due to the complexity of the disease state and the treatment bundle timing.

iii. **PC-02: Cesarean Birth Core Measure**. No new data for this month.

iv. **ED Throughput**. This measure reflects the amount of time from ED arrival to discharge 'home' from the ED. Year to date is 171 minutes, unfavorable to target of 162 minutes. February performance remains stable, in spite of increasing volume trends and a 20% increase in ED volume compared to this time last year. Dr. Bhimani will be bringing a focused review of improvement efforts to decrease ED throughput to our next Quality Committee Meeting as requested at the March Quality Committee Meeting.

Emergency Room

ED Visits	MTD FY22	MTD FY23	Delta	% Change
MV ED Visits	2,629	3,130	501	19.1%
LG ED Visits	832	1,041	209	25.1%
Total ED Visits	3,461	4,171	710	20.5%
MV/Day	138	165		
LG/Day	44	55		
TOTAL/DAY	182	220	37	20.5%
MV Admits from ED	25%	22%		
LG Admits from ED	19%	15%		

B. Patient Experience Measures

i. Inpatient units, likelihood to recommend top box. February performance is 74.4, unfavorable to target of 81.0. Not shown on the control chart is patient experience scores based on date of discharge for month of February which shows significant improvement in some units which has improved due to focused executive and patient experience rounding which began Feb 1, 2023. This improvement trend will be visible on our dashboard next month. The data shown on our dashboard reflects data based on 'date survey response was received'. This can obscure seeing real time improvement from recently deployed process improvement efforts.
ii. Maternal Child Health exceeds target for February 2023 (favorable) and improvement from January 2023 is sustained.
iii. ECHMN LTR performance for February 2023 is 84.1 which is favorable to target of 83.4.

Enterprise Quality, Safety and Experience Dashboard through October 2022
April 3, 2023

List of Attachments

Attachment 1-- Enterprise Quality, Safety, and Experience Dashboard February 2023

FY23 Enterprise Quality, Safety, and Experience Dashboard

February 2023 (unless otherwise specified)

Month to Board Quality Committee: April, 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: Feb, 23*	0.959	0.970	1.066	0.986 (7.5% ↓)	HAC Weighted Rate: Jul-22 – Feb-23	HAC FYTD Weighted Rate, Target ≤ 0.986
2	**HAC component** **Clostridium Difficile Infections (C-Diff)** *Latest data month: Feb, 23*	3	3.25 / month	3.08 / month	2.85 / month	# of C-Diff: Jul-22 2, Aug-22 3, Sep-22 2, Oct-22 6, Nov-22 3, Dec-22 4, Jan-23 3, Feb-23 3	C-Diff Infections FYTD, Target ≤ 34
3	**HAC component** **Surgical Site Infections (SSI)** *Latest data month: Feb, 23*	0	2.00 / month	1.50 / month	1.39 / month	# of SSIs: Jul-22 1, Aug-22 2, Sep-22 3, Oct-22 2, Nov-22 4, Dec-22 4, Jan-23 0, Feb-23 0	SSI FYTD, Target ≤ 16.65

FY23 Enterprise Quality, Safety, and Experience Dashboard

February 2023 (unless otherwise specified)

Month to Board Quality Committee: April, 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: Feb, 23*	7	8.25 / month	9.58 / month	8.86 / month	# of nvHAP: Jul-22 10, Aug-22 6, Sep-22 10, Oct-22 5, Nov-22 16, Dec-22 10, Jan-23 2, Feb-23 7	nvHAP FYTD; Target ≤ 106
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: Feb, 23*	16	12.38 / month	12.75 / month	11.79 / month	# of Patient Falls: Jul-22 7, Aug-22 9, Sep-22 9, Oct-22 22, Nov-22 12, Dec-22 16, Jan-23 8, Feb-23 16	Falls - IP Units FYTD; Target ≤ 142
6	**HAC component** **HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury** *Latest data month: Feb, 23*	0	0.50 / month	0.67 / month	0.62 / month	# of HAPIs: Jul-22 0, Aug-22 2, Sep-22 0, Oct-22 1, Nov-22 1, Dec-22 0, Jan-23 0, Feb-23 0	HAPIs FYTD; Target ≤ 7.4

FY23 Enterprise Quality, Safety, and Experience Dashboard

February 2023 (unless otherwise specified)

Month to Board Quality Committee: April, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
7	**Serious Safety Event Rate (SSER)** **Latest data month: Dec, 22*	4	3.13 (65/207352)	3.10 (Jul, 21 - Jun, 22)	n/a		
8	**Readmission Index (All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** ** Latest data month: Jan, 23*	0.97 (8.73%/9.01%)	1.05 (9.21%/8.79%)	1.05	1.00		
9	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Feb, 23*	1.16 (2.55%/2.20%)	1.08 (2.15%/2.00%)	0.94	0.85		

FY23 Enterprise Quality, Safety, and Experience Dashboard

February 2023 (unless otherwise specified)

Month to Board Quality Committee: April, 2023

#	Measure	FY23 Performance: Latest month	FY23 Performance: FYTD	Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
10	**Sepsis Mortality Index** *Observed/Expected* ***Premier Care Sciences Standard RA*** *Latest data month: Feb, 23*	1.43 (20.00%/14.01%)	1.16 (13.93%/12.03%)	1.03	0.98		
11	**PC-01: Elective Delivery Prior to 39 weeks gestation** (reported quarterly) **Latest data quarter: Sept, 22*	MV: 0.0% (0/24) LG: 0.0% (0/9) ENT: 0.0% (0/33)	MV: 0.0% (0/77) LG: 0.0% (0/27) ENT: 0.0% (0/104)	MV: 0.4% (1/271) LG: 3.5% (3/83) ENT: 1.1% (4/356)	1.5% (FY23 Target)		
12	**PC-02: Cesarean Birth** (reported quarterly) **Latest data quarter: Sept, 22*	MV: 37.0% (50/135) LG: 20.5% (8/39) ENT: 33.3% (58/174)	MV: 30.5% (146/479) LG: 21.4% (24/112) ENT: 28.8% (170/591)	MV: 27.1% (503/1,857) LG: 19.9% (83/147) ENT: 25.8% (586/2,274)	23.9% (FY23 Target)		

FY23 Enterprise Quality, Safety, and Experience Dashboard

February 2023 (unless otherwise specified)

Month to Board Quality Committee: April, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
13	**Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: Feb, '23*	MV: 192 mins LG: 144 mins ENT: 168 mins	MV: 199 mins LG: 142 mins ENT: 171 mins	MV: 190 mins LG: 133 mins Ent: 162 mins	MV: 190 mins LG: 133 mins Ent: 162 mins	UCL: 277; LCL: 61	Ent rolling 12 mo average; Enterprise Target / Goal; MV rolling 12 mo average; LG rolling 12 mo average
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Feb, 23*	74.4	78.5	80.8	81.0	UCL: 85.8; LCL: 75.2	
15	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Feb, 23*	83.7	74.6	81.3	81.5	UCL: 91.3; LCL: 71.4	

FY23 Enterprise Quality, Safety, and Experience Dashboard

February 2023 (unless otherwise specified)

Month to Board Quality Committee: April, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
16	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: Feb, 23*	73.7	72.3	74.5	75.0	UCL: 83.1; LCL: 68.3 (Mar-21 to Feb-23)	
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: Feb, 23*	84.1	82.0	83.2	83.4	Mar-22: 80.5; Apr-22: 78.2; May-22: 83.2; Jun-22: 85.7; Jul-22: 78.7; Aug-22: 82; Sep-22: 82.6; Oct-22: 82.7; Nov-22: 79.5; Dec-22: 82.7; Jan-23: 83.3; Feb-23: 84.1	NA

Notes:

1) SSER through Dec, 22
2) Readmissions through Jan, '23
3) PC-01 & PC-02 FY23Q1 (July - Sept 2022) results available
4) ECHMN: reflect new vendor (PG) survey results
5) Updated 3/21/23

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
1	*Organizational Goal **HAC Index** *Latest data month: Feb, 23*		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: Feb, 23*		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: Feb, 23*		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

#	Metric	Comments	Definition Owner	Definition	Source
4	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: Feb, 23*		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: Feb, 23*		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: Feb, 23*		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

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Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
7	**Serious Safety Event Rate (SSER)** **Latest data month: Dec, 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. New classification rules in effect as of 7/1/22	HPI Systems
8	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** ** Latest data month: Jan, 23*		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: Feb, 23*		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

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
10	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Feb, 23*		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: Sept, 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
12	**PC-02: Cesarean Birth** (reported quarterly) **Latest data quarter: Sept, 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

El Camino Health

Definitions and Additional Information

#		Comments	Definition Owner	Definition	Source
13	**Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: Feb, '23*		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: Feb, 23*		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
15	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Feb, 23*		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

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
16	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: Feb, 23*		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: Feb, 23*		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 Dec, 22
2) Readmissions through Jan, '23
3) PC-01 & PC-02 FY23Q1 (July - Sept 2022) r
4) ECHMN: reflect new vendor (PG) survey
5) Updated 3/21/23

As of: 3/7/23

Quality Committee Follow-Up Items

Item	Date Requested	Committee Member Name	Item Requested	Individual to complete the follow up	Completion Date
FY23					
1	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
2	9/6/2022	Carol Somersille, MD	item dated 06/06/2022 to her name and remove Holly Beeman's name under Committee Member.	Nicole Hartley	9/7/2022
3	11/7/2022	John Zoglin	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
4	11/7/2022	Alyson Falwell	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
5	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
6	2/6/2023	Krutica Sharma, MD	Requested that we add a monthly threshold or target line to the trend chart on the Enterprise Dashboard	Dr. Holly Beeman	3/6/2023
7	2/6/2023	Krutica Sharma, MD	Request the action plan for complying with the new Joint Commission patient safety goal regarding Health Equity be shared with the committee at a future meeting.	Dr. Holly Beeman	
8	3/6/2023	Melora Simon	Deep Dive on emergency department times and throughput at a future meeting.	Dr. Meenesh Bhimani/Cheryl Reinking	

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: April 3, 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 the hospital.

2. Authority: To provide insight into one patient's experience and the importance of including families early in the discharge instruction process.

3. Background: This patient provided very helpful feedback regarding the discharge instruction process and the inclusion of family members early in the process.

4. Assessment: This feedback is very helpful for our staff to understand the importance of including family members early in the discharge education process and the need to have different modalities of patient education available. Families need to learn much in a short time for taking care of their loved ones. The hospital is exploring options to provide video discharge instructions as other organizations have done. In addition, with the increase in visitation hours and numbers of visitors, the opportunity to include families has broadened.

5. Other Reviews: None

6. Outcomes: We will continue to monitor our comments and our Press Ganey scores and continue to incorporate video and other alternative family/patient education methodologies.

7. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. How will you evaluate the best alternative patient education tools to use?

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

Patient Story
April 3, 2023

Press Ganey Survey Comment

The discharge process is a bit chaotic and confusing. There should be more information given to caregivers since they will be the ones caring for patients. Especially if the patient has needs beyond just taking pills, caregiver should be informed of expectations and needs of patient not minutes before discharge just in case there are questions about after care. This will also reduce the amount of return visits due to improper training or information about aftercare. The care at the hospital was good but there needs to be a better communication and care of patient after being released.

FY24 COMMITTEE GOALS

Quality, Patient Care, and Patient Experience Committee

PURPOSE

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

STAFF: **Holly Beeman, MD, MBA,** Chief Quality Officer (Executive Sponsor)

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

GOALS	TIMELINE	METRICS
1. Ensure the metrics included on the Quality Committee dashboards (Enterprise Quality, Patient Care and Patient Experience dashboard, and STEEEP) are in alignment with the enterprise strategic plan.	Q4FY23 review and update which measures to include on the FY24 quarterly board STEEEP report.	- Enterprise quality dashboard measures and targets - STEEEP dashboard measures and targets.
2. Monitor Quality, Patient Care and Patient Experience performance in accordance with the pacing plan to track progress towards achieving targets.	Q4FY23, review FY24 Incentive Goal recommendations for Quality, Safety and Patient Experience measures and targets.	- Monthly Enterprise dashboard measures with targets and performance - Quarterly STEEEP dashboard with targets and performance
3. Identify and reduce health care disparities for ECH patients.	Biannual report to Quality Committee FY24.	- Monitor the effectiveness of ECH activities to reduce health care disparities in the individuals we serve
4. Foster a culture of collaboration, transparency, and continuous improvement within the Quality Committee by implementing regular feedback mechanisms, encouraging open communication, and promoting a shared sense of responsibility for achieving quality outcomes. ~~All committee members regularly attend and are engaged in committee meeting preparation and discussions~~	Using closing wrap up time, review quarterly at the end of the meeting.	- Attend a minimum of 7 meetings in person - Actively participate in discussions at each meeting - Positive score on annual committee assessment
5. Educational Session with the Committee. ~~Patient Experience Aptitude~~		- Conferences - Session with subject matter expert. ~~Participation in training sessions [this is just a starting point and can be updated with discussion]~~

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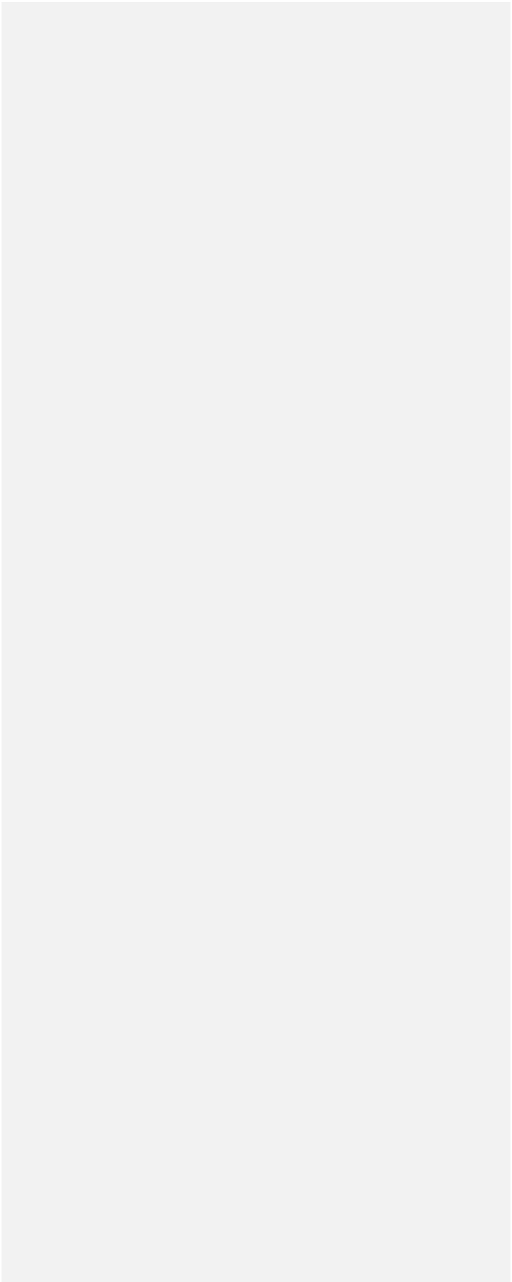
Chair: Carol Somersille, MD
Executive Sponsor: Holly Beeman, MD, MBA, Chief Quality Officer



El Camino Health

El Camino Hospital Board of Directors
Quality, Patient Care and Patient Experience Committee Charter

Purpose

The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality Committee" or the "Committee") is to advise and assist the El Camino Hospital Board of Directors ("Board") to monitor and support the quality and safety of care provided at El Camino Health. The Committee will utilize the Institute of Medicine's framework for measuring and improving quality care in these five domains: **s**afe, **t**imely, **e**ffective, **e**fficient, **e**quitable, and **p**erson-centered (STEEEP).

El Camino Health management will provide the Committee with standardized quality metrics with appropriate benchmarks, when available, so that the Committee can adequately assess the ~~level of~~ quality of care being provided. ECH Management and Quality Committee members will collaborate to identify and improve opportunities for quality improvement.

Authority

All governing authority for the Organization resides with the Hospital Board for ECH and with the boards of the affiliated entities except that which may be lawfully delegated to a specific board committee. The Committee will report to the Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. The Committee has the authority to select, recommend engagement, and supervise any consultant hired by the Board to advise the Board or Committee on issues related to clinical quality, safety, patient care and experience, risk prevention/risk management, and quality improvement. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Voting members of the Committee shall include the directors assigned to the Committee, *ex-officio* members and alternates and external (non-director) members appointed to the Committee.

Membership

- The Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.

- The Committee shall also include the Enterprise Chief of the Medical Staff and the Los Gatos Campus Chief of Staff as *ex officio* voting members of the Committee. The Enterprise Vice Chief of Staff or the Los Gatos Vice Chief of Staff shall serve as alternate voting members of the Committee and replace, respectively the Enterprise Chief of Staff or the Los Gatos Chief of Staff if such person is absent from a Committee meeting.

- The Quality Committee may also include 1) no more than nine (9) Community members[1] with expertise in ~~in~~ - assessing quality indicators, quality processes ~~(*e.g.*, LEAN)~~, patient

[1] Community Members are defined as Members of the Committee who are not El Camino Hospital Board Directors or *ex-officio* members or alternates.

safety, care integration, payor industry issues, customer service issues, population health management, alignment of goals and incentives, or medical staff members, and members who have previously held executive positions in other hospital institutions (*e.g.*, CNO, CMO, HR) as well as other areas as needed and 2) no more than two (2) patient advocate members who have had significant exposure to ECH as a patient and/or family member of a patient. Approval of the full Board is required if more than nine Community members are recommended to serve on this Committee.

- All Committee members, with the exception of new Community members, *ex-officio* members and alternates, shall be appointed by the Board Chair, subject to approval by the Board. New Community members shall be appointed by the Committee, subject to approval of the Board. All Committee appointments shall be for a term of a minimum of 12 months expiring on June 30th each year, renewable annually.

- It shall be within the discretion of the Chair of the Committee to appoint a Vice Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board Director, the Vice Chair of the Committee shall be a Hospital Board Director.

Executive Support and Participation

The ~~Chief Medical Officer (CMO)~~Chief Quality Officer (CQO) shall serve as the primary executive to support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives as well as members of the executive team may participate in the Committee meetings upon the recommendation of the ~~CMO~~ CQO and subsequent approval from both the CEO and Committee Chair.~~.~~

General Responsibilities

The Committee will collaborate with management to identify opportunities for quality and safety improvement. The Committee will support the implementation and monitoring of process improvement plans to address and close quality and safety gaps. Members of the Quality Committee will model behaviors, attitudes and actions consistent with the ECH tenets of a High Reliable Organization, specifically, focusing on creating strong relationships between everyone on the team to engender a culture of psychological safety which promotes our ECH ~~culture of safety~~mission to achieve zero patient harm. ~~the~~ The management team shall develop dashboard metrics that will be used to measure and track quality, safety and patient experience performance~~.~~ ~~of care and outcomes, and patient satisfaction~~ for the Committee's review and subsequent approval by the Board. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for 1) ensuring ~~that~~ performance metrics meet the Board's expectations; 2) aligning those metrics and associated process improvements to the quality plan, strategic plan, organizational goals; and 3) ensuring ~~that~~ communication to the Board and external constituents is well executed.

Specific Duties

The Committee shall partner with management to support the following activities:

1. Quality Planning—Ensure the enterprise strategy plan is quality-centric.
2. Quality Control—Review quality processes and performance on a regular basis.
3. Quality Improvement—Review performance of major process improvement projects on a regular basis.

Specific duties of the Committee include the following:

- ~~Oversee management's development of a multi-year strategic quality plan (PaCT).~~

- Review and approve which measures to include and track on the quarterly Board Quality Report (STEEEP).~~.~~ ~~an annual~~ "Quality Dashboard" for tracking purposes.

- Oversee management's development of the Organization's goals encompassing the measurement and improvement of ~~safety, risk, efficiency, patient-centeredness, patient satisfaction~~quality, safety and patient experience~~, and the scope of continuum of care services~~ as tracked on the Enterprise Quality, Patient Care and Patient Experience Dashboard~~.~~

- Review reports related to Organization-wide quality and patient safety initiatives in order to monitor and oversee the quality of patient care and service provided. Reports will be provided in the following areas:

  - Organization-wide performance regarding the quality care initiatives and goals highlighted in the strategic plan.
  - Organization-wide patient safety goals and hospital performance relative to patient safety targets.
  - Organization-wide patient safety surveys (including the culture of safety survey), sentinel event and red alert reports, and risk management reports.
  - ~~Organization-wide LEAN management activities and cultural transformation work.~~
  - Organization-wide patient satisfaction and patient experience surveys.
  - Organization-wide ~~physician~~ provider satisfaction surveys.

- Ensure the organization demonstrates proficiency through full compliance with regulatory requirements~~, to including, but limited to,~~ including, but not limited to The Joint Commission (TJC), Department of Health and Human Services (HHS), California Department of Public Health (CDPH), and Office of Civil Rights (OCR).

- In cooperation with the Compliance Committee, review results of regulatory and accrediting body reviews and monitor compliance and any relevant corrective actions with accreditation and licensing requirements.

- Review ~~Sentinel Events (SE), Seriously Safety Events (SSE), and red alerts~~annual report on actions taken to improve patient safety as per the ~~hospital and boa~~Safety Event Reporting~~rd~~ policy that is maintained in PolicyStat.

- Oversee organizational quality and safety performance improvement for both the Organization's and medical staff activities.

- ~~Ensure that the Organization's scope of service and community activities and resources are responsive to community need.~~

- Review the Medical Executive Committee's monthly credentialing and privileging reports and make recommendations to the Board.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and the Organization's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board. Committee members shall be responsible for keeping themselves up to date with respect to drivers of change in healthcare and their impact on quality activities and plans.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be ~~forwarded~~ shared to the Board for information.

Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of committees may also be called by resolution of the Board or the Committee Chair. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the Committee. Notice of any special meetings of the Committee requires a 24-hour notice.

El Camino Health

DRAFT

Quality, Patient Care, and Patient Experience Committee
FY24 Pacing Plan

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			✓									
Annual Culture of Safety Survey Report			✓									
Patient Experience ~~(HCAHPS)~~			✓						✓			
Health Care Equity						✓						✓
Safety Report for the Environment of Care					✓							
PSI Report						✓						
Sepsis Review						✓						
Value Based Purchasing Report										✓		
Approve Quality Assessment & Performance Improvement Plan (QAPI)												✓
Refresh STEEEP Dashboard measures for FY25												✓
Special Topic (Placeholder)			✓							✓		
COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR												
Propose Committee Goals									✓			
Approve Committee Goals										✓		
Propose FY Committee Meeting dates									✓			
Approve FY Committee Meeting dates										✓		
Propose Organizational Goals										✓		
Approve FY23 Organizational Goals										✓	~~✓~~	
Propose Pacing Plan									✓			
Approve Pacing Plan										✓		
Review 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, Patient Safety Report (Sept), CDI Dashboard (Semi-Annual), Core Measures (Semi-Annual), Leapfrog (June)

El Camino Health

Quality Committee Meetings
Proposed FY2024 Dates

RECOMMENDED QC DATE MONDAYS
Monday, August 7, 2023
Tuesday, September 5, 2023 ***Moved due to the Holiday**
Monday, November 6, 2023
Monday, December 4, 2023
Monday, February 5, 2024
Monday, March 4, 2024
Monday, April 1, 2024
Monday, June 3, 2024

*Goal is to reduce the # of meetings by 1

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: April 3, 2023
Subject: Process for selection of FY24 Organizational Quality Goal

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on process to identify the FY24 Organizational Quality Goal.

Summary:

Situation: The organizational quality goal for FY23 is the Hospital Acquired Condition Index which includes 5 measures, 3 of which are publicly reported and impact our performance on CMS 5 star rating and Leapfrog Safety grades. Patient falls and non-ventilator hospital acquired pneumonia are not included in the calculation of these publicly reported quality and safety grades. Management will select measures for FY24 which are included in BOTH CMS 5 star ratings and Leapfrog Safety grades. The criteria used to select which measures to elevate to organization goal will be based on these criteria.

- Does the measure impact both Leapfrog Safety grade and CMS star rating?
- Is current performance putting ECH at risk of down-grading from CMS 5 star and/or Leapfrog A?
- Weighting of the measure for CMS Star Rating
- Weighting of the measure for Leapfrog Safety grade

Assessment: Based on initial review of the preliminary spring Leapfrog grades, the areas of focused improvement for FY24 are likely to be;

1. C. Difficile Infection
2. Catheter Associated Urinary Tract Infection
3. Central Line Associated Bloodstream Infection

Recommendation: A composite measure based on the above criteria will be shared with the Quality Committee in the May 2023 meeting.