El Camino Health

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

Monday, November 7, 2022 – 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: 997 0320 5395#. 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 (09/06/2022) ***Information*** b. Report on Board Actions c. FY23 Pacing Plan d. FY23 Enterprise Quality Dashboard e. CDI Dashboard f. Core Measures g. QC Follow-Up Items h. Article of Interest			
5.	**CHAIR'S REPORT**	Carol Somersille, MD Quality Committee Chair		**information** **5:47 – 5:57**
6.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer		**discussion** **5:57 – 6:07**
7.	**SAFETY REPORT FOR THE ENVIRONMENT OF CARE**	Ken King, Chief Administrative Services Officer	*public comment*	**motion required** **6:07 – 6:22**
8.	**Q1 FY23 STEEEP DASHBOARD REVIEW**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion** **6:22 - 6:42**

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.	**EL CAMINO HEALTH MEDICAL NETWORK REPORT**	Shahab Dadjou, Interim President, El Camino Health Medical Network Ute Burness, VP of Quality and Payer Relations		**discussion 6:42 – 7:02**
10.	**ADJOURN TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 7:02 – 7:03**
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair		**information 7:03 – 7:04**
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 (09/06/2022) b. Quality Council Minutes (09/07/2022) c. Quality Council Minutes (10/05/2022)	Carol Somersille, MD Quality Committee Chair		**motion required 7:04 – 7:09**
13.	*Health and Safety Code Section 32155* **CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer		**motion required 7:09 – 7:19**
14.	*Health and Safety Code Section 32155* **Q1 FY23 QUARTERLY QUALITY AND SAFETY REVIEW OF REPORTABLE EVENTS**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 7:19 – 7:29**
15.	*Health and Safety Code Section 32155* **SERIOUS SAFETY/RED ALERT EVENT**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 7:29 – 7:34**
16.	**ADJOURN TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair		**motion required 7:34 - 7:35**
17.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair		**information 7:35 – 7:36**
18.	**CLOSING WRAP UP**	Carol Somersille, MD Quality Committee Chair		**discussion 7:36 – 7:39**
19.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 7:39– 7:40 pm**

Next Meeting: December 12, 2022, February 6, 2023, March 6, 2023, April 3, 2023, 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
Tuesday, September 6, 2022
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent
Carol Somersille, MD	**Alyson Falwell**
Philip Ho, MD	**Prithvi Legha,** MD
Jack Po, MD	
Krutica Sharma, MD**	
Melora Simon**	
John Zoglin	

**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 5:31 pm by Chair Carol Somersille. A verbal roll call was taken. Ms. Falwell and Dr. Legha were absent. Ms. Simon joined at 5:34 pm. 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 4c – FY23 Enterprise Quality Dashboard. Chair Somersille requested to pull items 4c – FY23 Enterprise Quality Dashboard, 4d – Progress Against FY23 Committee Goals, and 4e – QC Follow-Up Items. Mr. Zoglin asked why we have absolute numbers versus percentages. Dr. Beeman shared that each nursing unit has chosen one of the HAC measures as their annual goal. This dashboard is a 'working' dashboard. Showing the events as a raw number is more relatable and engaging for the managers and front line staff. Chair Somersille asked about number 11 – Elective Delivery Prior to 39 weeks' gestation and suggested that we change the metric to Exclusive Breastfeeding due to the low count in the current metric and the focus on Exclusive Breastfeeding.	***Consent Calendar Approved***

	Dr. Adams responded stating he will bring the recommendation to the maternal child health department. He also noted a correction for number 7 – Serious Safety Event Rate on the attached Enterprise Dashboard. The Baseline FY22 Actual is 3.10, not 3.13. Chair Somersille addressed item 4d – Progress Against FY23 Committee Goals. She noted to correct the Chair name to her name and remove Julie Kliger's name. Chair Somersille addressed item 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 under Committee Member. **Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (08/01/2022); For information: (b) Report on Board Actions, (c) FY23 Enterprise Quality Dashboard, (d) Progress Against FY23 Committee Goals (e) QC Follow-Up items **Movant**: Zoglin **Second**: Po **Ayes**: Somersille, Ho, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Falwell, Legha **Recused**: None	*Action: Nicole to correct the Chair's name on the FY23 Committee Goals* *Action: Nicole to correct the Committee Member name on the QC Follow-Up Items.*
5. CHAIR'S REPORT	Chair Somersille referenced the FY23 Committee Goals and highlighted the goal of Committee Members attending 2/3 of all meetings in-person and discussed the importance of attending in-person.	
6. PATIENT STORY	Cheryl Reinking, CNO shared feedback from a patient via Press Ganey survey regarding her experience in the LG ED. The patient had a procedure at a different facility and the IV site became inflamed. The patient went to her PCP and received a cream for the infected site. Later on, the inflammation continued and the patient reached back out to the PCP who referred the patient to a Dermatologist. The patient was unable to get a Dermatology appointment and ended up being referred to Urgent care due to the continued inflammation. She did receive care at the Lincoln Ave Urgent Care, but had to wait a long period of time to be seen. She was referred to LG ED from urgent care for continued care such as IV antibiotics that only can be infused in the ED. Once at the ED, the patient received excellent care to address her infected hand. With this feedback, we will identify the gaps and work on improvements of care. Chair Somersille asked if there is an outpatient follow-up protocol for urgent needs. Cheryl responded that she does not believe there is. Chair Somersille recommended that we should look into this. Dr. Shin shared his insights as to what occurs for	

	primary care and specialist physicians at PAMF when a patient needs to be seen urgently.	
7. PATIENT EXPERIENCE (HCAHPS)	Christine Cunningham, Chief Experience Officer presented on Patient Experience (HCAHPS) and reviewed the following: • ECH Pyramid and the 5 Strategic Pillars • Evolving Patient Expectations • The Power of Patient and Family Voice • Patient Experience Industry Best Practices • Likelihood to Recommend Measure and FY22 Results • Service Comparison • Likelihood to Recommend Trends • FY23 LTR Targets • FY23 Opportunities based on FY22 and 3-year trends • Priorities for FY23 • ECHMN 3-year trend • The Loyalty Formula • Frictionless Experience Dashboard, Journey Maps Mr. Zoglin suggested updating the pyramid to the current pyramid that includes our strategy. Mr. Zoglin asked if we are able to get data to compare us to the top quartile or decile. Christine shared that Press Ganey does not provide that information but will follow up to see if we can get the top quartile or decile data and how we compare. Mr. Zoglin also asked if the decile target can be shared with the Committee to ensure we are aligned with the strategy. Ms. Simon asked about the progress we have made over the past 5-10 years and whether we have dramatically moved the needle or have we stayed within the statistical bound. Christine shared that a 5-year analysis has been completed and we have increased in every service line and is happy to share this analysis with the Committee. Jack Po agreed with the need for the 5-year analysis. Chair Somersille agreed and asked if it can be shared with the Committee how the targets are determined. Chair Somersille also asked Christine to share a paper that was recently written for the Patient Experience Journal with the Committee.	

8. HIGH RELIABILTY UPDATE	Dr. Mark Adams, CMO gave a verbal update regarding the High Reliability journey and highlighted the following:
	• Currently educating the organization of the principles of High Reliability
	• High Reliability & Serious Safety event definition
	• S.A.F.E.T.Y. is our brand for Safety First/Mission Zero
	  ○ Speak up for safety
	  ○ Accurate communication
	  ○ Focus on the task
	  ○ Embrace a questioning attitude	

	○ Take thoughtful action ○ You and me together • Advised that the 2-hour HRO class could be presented for the next Board education session.	
9. HEALTH EQUITY METRICS	Dr. Holly Beeman, CQO presented on Health Equity Metrics and highlighted the following: Our new CHRO will be focusing on the work place diversity inclusion and belonging. Quality team will be focused on our patients and health equity for our patients. Dr. Beeman referenced the memo provided in the committee packet in which the types of self-reported information we collect from our patients is described in detail. Mr. Zoglin asked about the genetic component of asking our patients social determinants of health questions and why is this not included. Dr. Beeman shared that genetic question may be in the future phase of the process. Ms. Simon referenced the presentation and that it states we are mapping to the community but the Hispanic cell is blank. Dr. Beeman shared that the column in the table is data from the U.S. Census Bureau. The U.S. Census Bureau considers Hispanic an ethnicity, not a race. So, individuals are not given Hispanic as an option to select for race. That is why this cell is blank.	
10. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 7:01 pm. **Movant**: Somersille **Second**: Po **Ayes**: Somersille, Ho, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Falwell, Legha **Recused**: None	***Adjourned to closed session at 7:01 pm***
11. AGENDA ITEM 17: RECONVENE OPEN SESSION/REPORT OUT	The open session reconvened at 7:45 pm. Agenda items 11-16 were addressed in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (08/01/2022), the Quality Council Minutes (08/03/2022), and the Medical Staff Credentialing and Privileges Report by unanimous vote by all committee members present.	
12. AGENDA ITEM 18: CLOSING WRAP UP	No additional Comments	
13. AGENDA ITEM 19: ADJOURNMENT	**Motion**: To adjourn at 7:47 pm **Movant**: Po **Second**: Simon **Ayes**: Somersille, Ho, Po, Sharma, Simon, Zoglin	***Adjourned at 7:47 pm***

	Noes: None **Abstain**: None **Absent**: Falwell, Legha **Recused**: None	

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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: Stephanie Iljin, Manager of Administration
Date: November 07, 2022
Subject: Report on Board Actions

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

Summary:

1. Situation: It is essential to keep the Committees informed about Board activity to provide context for Committee work. The list below is not meant to be exhaustive; still, it includes agenda items the Board voted on that are most likely to be of interest to or pertinent to the work of El Camino Hospital's Board Advisory Committees.

2. Authority: This is being brought to the Committees at the request of the Board and the Committees.

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

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	September 14, 2022	- Credentialing and Privileges Report - Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings - Exception to Physician Financial Arrangements Policy - Neuro-Interventional Call Panel (MV) - FY2023 Period 1 Financials
	October 12, 2022	- Credentialing and Privileges Report - MV Otolaryngology ED and Inpatient Call Panel Renewal - Enterprise Neurology, Neurodiagnostic, and Neurohospitalist Coverage - Executive Compensation Committee Approvals - Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings - FY2023 Period 2 Financial Report - FY2022 Audited Financial Report - FY2022 CEO Performance Incentive Individual Score - FY2022 CEO Performance Incentive Plan Payout - FY2023 CEO Base Salary - FY2022 Organization Performance Incentive Plan Score

Report on Board Actions
November 07, 2022

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECHD Board	October 18, 2022	- Community Benefits Spotlight Resolution 2022-11: Day Worker Center of Mountain View - Continuation of Resolution 2021-10; AB361 - Resolution 2022-08: Appointment of FY2023 El Camino Hospital Board Member Ad Hoc Committee Advisory Members - FY2022 Year-End Community Benefit Report - Community Benefit Sponsorship Report - Report on Covid-19 Community Program - FY2023 Pacing Plan - ECHD FY2022 Financials - FY2022 Audited Financial Report
Executive Compensation Committee	September 13, 2022	- Proposed FY2022 Individual Performance Incentive Plan Scores - Proposed FY2023 Individual Executive Strategic Pick Goals (COO & CGO) - Proposed FY2023 Executive Base Salaries
Compliance and Audit Committee	September 28, 2022	- Review FY2022 Consolidated Financial Statements, 403 (b) and Cash Balance Audit Results - KPI Scorecard and Trends - Activity Log May – August 2022 - Internal Audit Work Plan - Internal Audit Follow-Up Table - Committee Pacing Plan
Finance Committee	September 27, 2022	- FY2023 Period 1 Financial Report - FY2023 Period 2 Financial Report - MV Imaging Equipment Replacement Project - Enterprise Neurology/Neurohospitalist Services - MV Otolaryngology Call Panel - MV Neurointerventional Call Panel

List of Attachments: None.

Suggested Committee Discussion Questions: None.

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 – MEDICAL STAFF ITEMS												
Medical Staff Office Audit Report					✓							
Report on Medical Staff Peer Review Process						✓						
Medical Staff Credential Process												✓
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		✓	✓						✓			✓
High-Reliability Progress									✓			
~~Culture of Safety Survey Results~~												
Safety Report for the Environment of Care					✓							
~~Readmission Dashboard~~												
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 FY23 Organizational Goals											✓	
Propose Pacing Plan										✓		
Approve Pacing Plan											✓	

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: November 7, 2022
Subject: Enterprise Quality, Safety and Experience Dashboard through September 2022

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety and experience metrics and performance through September 2022 (unless otherwise noted) as demonstrated on the FY23 Enterprise Quality, Safety and Experience Dashboard. The STEEEP Quarterly Board Dashboard for Q1 contains 15 of the 17 measures on the monthly Enterprise Dashboard. The two metrics not described in the memo accompanying the STEEEP dashboard will be reviewed here.

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. New on the attached FY23 dashboard are ECH Hospital Acquired Condition (HAC) Index, and, the individual 5 measures which make up the HAC index. The target for FY23 is to reduce the HAC Index by 7.5%, lower is better.

4. Assessment: Of the hundreds of performance measures tracked and actively managed, 17 measures are reported on the FY23 Enterprise Quality Dashboard.

    i. Serious Safety Event Rate. A desired result of our High Reliability Organization training and implementation is an increase in staff and physician reporting of safety events. We are encouraged to see this anticipated trend. There were 11 serious safety events in July FY2022. There intentionally is not a ‘target’ for the SSE rate in FY23.

    ii. Patient Throughput-Median Time: Arrival to ED Departure. Enterprise ED throughput time year to date is 334 minutes, unfavorable to target of 275

minutes. Having capacity on inpatient units, radiology turnaround time, and optimizing efficiency of hand offs from ED teams to inpatient teams are areas of focus. We are currently engaging with a consultant to identify opportunities for improvement.

List of Attachments

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

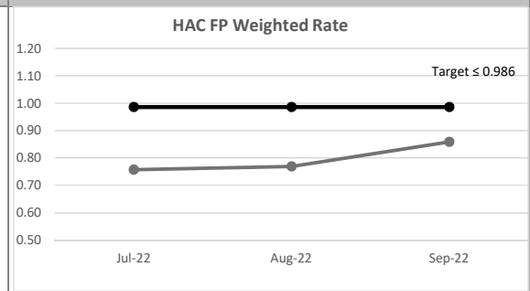
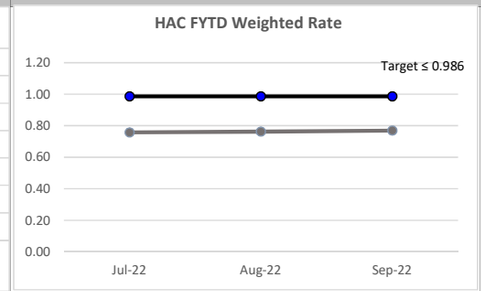
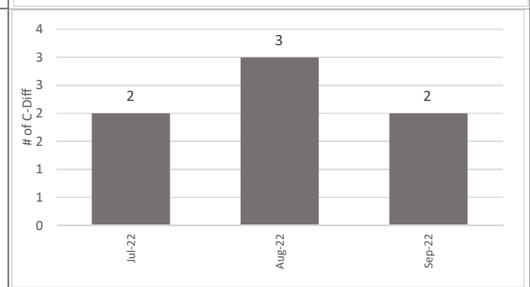
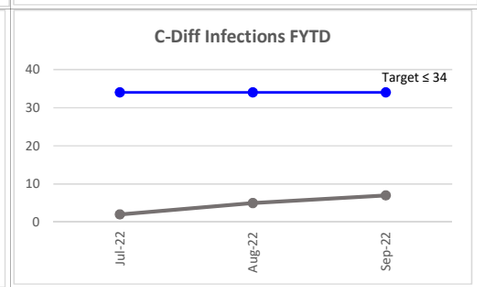
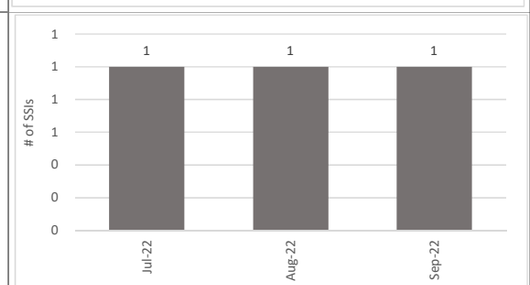
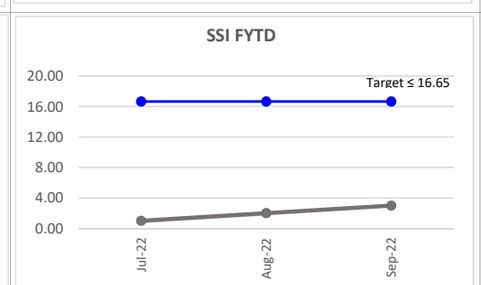
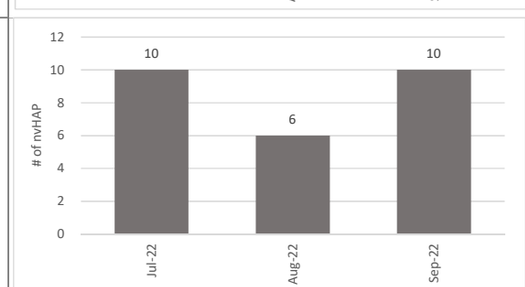
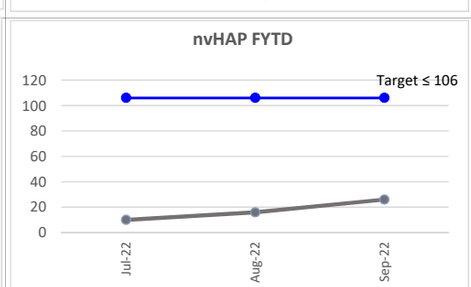
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

September 2022 (unless otherwise specified)

Month to Board Quality Committee:

November, 2022

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend *(showing at least the last 24 months of **available** data)*	FYTD or Rolling 12 Month Average	Measure Name
		Latest month	FYTD					
1	***Organizational Goal** **HAC Index** *Latest data month: Sep, 22*	0.86	0.77	1.066	0.986 (7.5% ↓)			**HAC Index: composite of monthly weighted rates of (5) component metrics listed below**
2	**HAC component** **Clostridium Difficile Infections (C-Diff)** *Latest data month: Sep, 22*	2	2.33 / mo	3.08 / mo	2.85 / mo (7.5% ↓)			**Clostridium Difficile Infection (C.diff)**
3	**HAC component** **Surgical Site Infections (SSI)** *Latest data month: Sep, 22*	1	1.00 / mo	1.50 / mo	1.39 / mo (7.5% ↓)			**Surgical Site Infections (SSI)**
4	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: Sep, 22*	6	8.67 / mo	9.58 / mo	8.86 / mo (7.5% ↓)			**Non-ventilator Hospital-Acquired Pneumonia (nvHAP)**

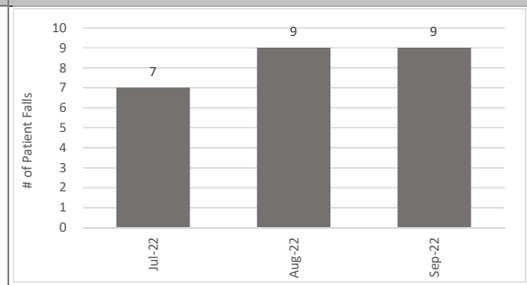
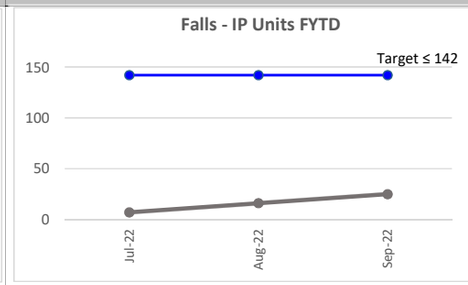
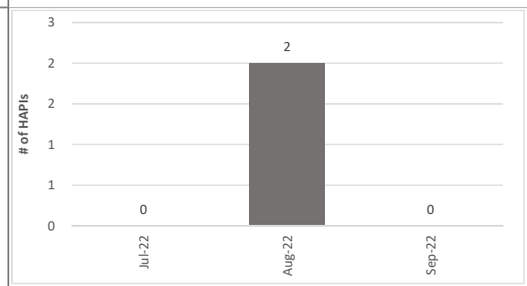
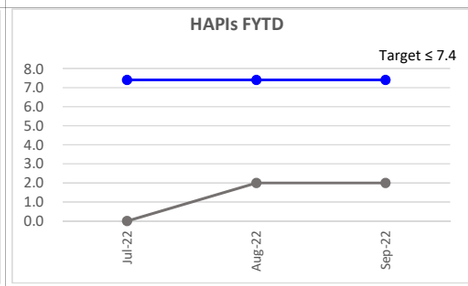
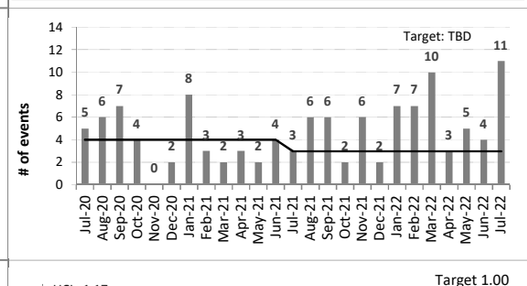
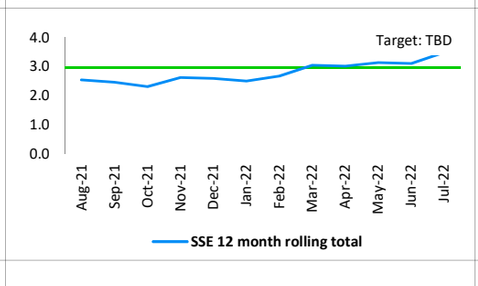
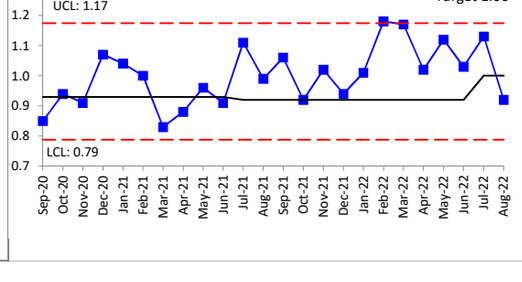
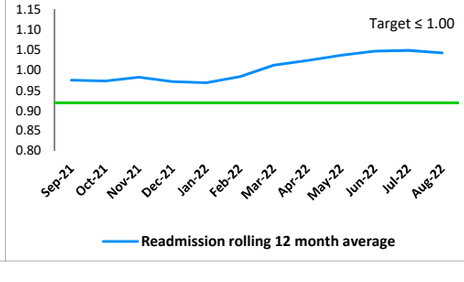
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

September 2022 (unless otherwise specified)

Month to Board Quality Committee:

November, 2022

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend *(showing at least the last 24 months of **available** data)*	FYTD or Rolling 12 Month Average	Measure Name
		Latest month	FYTD					
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: Sep, 22*	9	8.33 / mo	12.75 / mo	11.79 / mo (7.5% ↓)			**NDNQI: IP Units Patient Falls**
6	**HAC component** **HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury** *Latest data month: Sep, 22*	0	0.67 / mo	0.67 / mo	0.62 / mo (7.5% ↓)			**Stage 3, Stage 4 and Unstageable Hospital Acquired Pressure Injury (excludes skin failure and expired pts)**
7	**Serious Safety Event Rate (SSER)** # of events/ FYTD rolling 12 month per 10,000 Acute Adjusted Patient Days *Rate* ***Latest data month: Jul, 22*	11	3.48 (69/198156)	3.10 (Jul 2021 - Jun 2022)	TBD			**Serious Safety Event Rate (SSER)**
8	**Readmission Index (All Patient All Cause Readmit) *Observed/ Expected*** ***Premier Standard Risk Calculation Mode*** ***Latest data month: Aug, 22*	0.92 (7.89%/8.56%)	1.02 (8.76%/8.57%)	1.05	1.00			**Readmission Index - All Patient All Cause Readmit (Observed/Expected)**

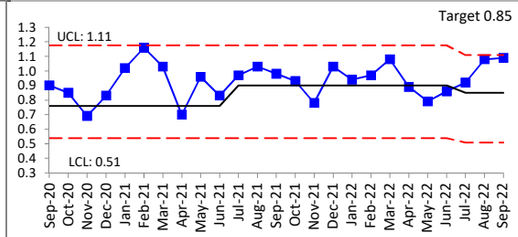
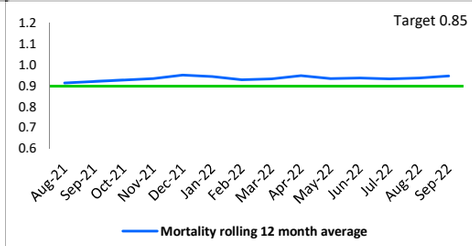
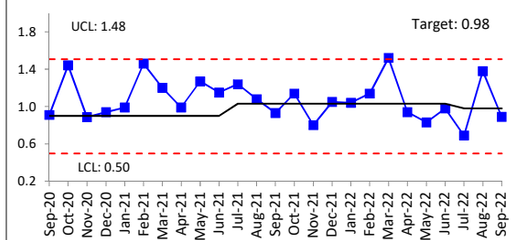
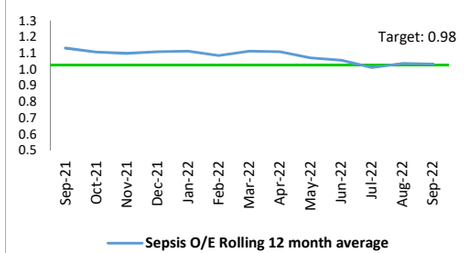
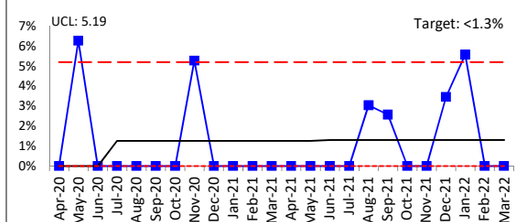
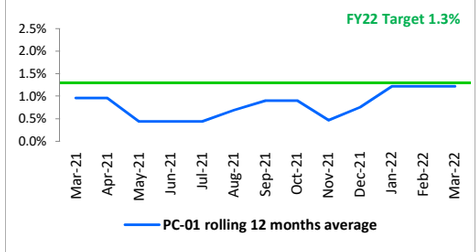
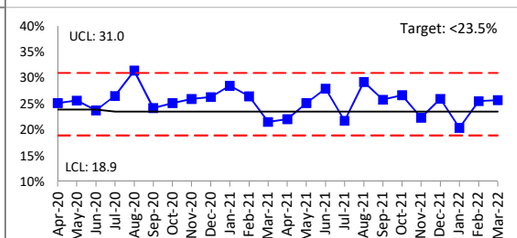
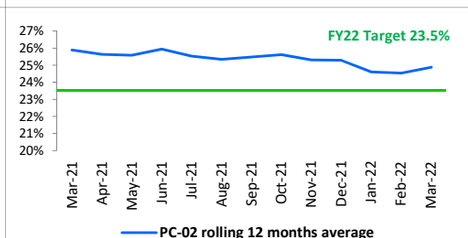
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

September 2022 (unless otherwise specified)

Month to Board Quality Committee:

November, 2022

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend *(showing at least the last 24 months of **available** data)*	FYTD or Rolling 12 Month Average	Measure Name
		Latest month	FYTD					
9	**Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: Sep, 22*	1.09 (1.82%/1.68%)	1.03 (1.73%/1.67%)	0.94	0.85			**Mortality Index (Observed/Expected)**
10	**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)* *Latest data month: Sep, 22*	0.89 (9.40%/10.54%)	1.02 (11.19%/10.98%)	1.03	0.98			**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)*
11	**PC-01: Elective Delivery Prior to 39 weeks gestation** (reported quarterly) *Latest data quarter: Mar, 22*	MV: 0.0% (0/16) LG: 0.0% (0/9) **ENT:** 0.0% (0/25)	MV: 0.5% (1/199) LG: 4.8% (3/63) **ENT: 1.5% (4/262)**	MV: 0.41% (1/244) LG: 0.0% (0/77) ENT: 0.3% (1/321)	1.25% (FY22 Target)			**NOTE: Results are not final until the quarterly submission to CMS. FY22 final results available after 11/1/22; included with next Ent DB publication Dec, '22. PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation**
12	**PC-02: Cesarean Birth** (reported quarterly) *Latest data quarter: Mar, 22*	MV: 28.6% (46/161) LG: 14.6% (6/41) **ENT:** 25.7% (52/202)	MV: 26.2% (377/1439) LG: 19.6% (65/332) ENT: 25.0% (442/1771)	MV: 27.3% (423/1551) LG: 20.6% (72/349) ENT: 26.10% (495/1900)	23.5% (FY22 Target)			**PC-02: Cesarean Birth - Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth**

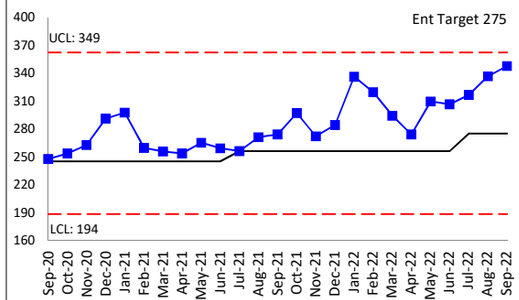
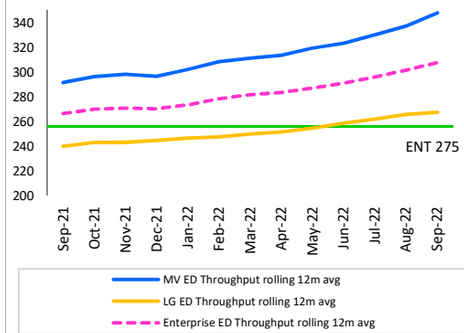
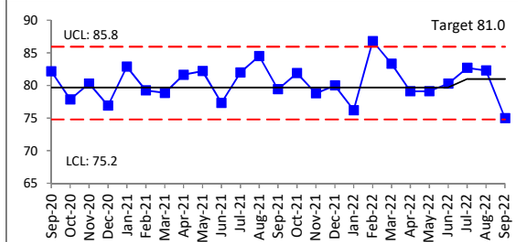
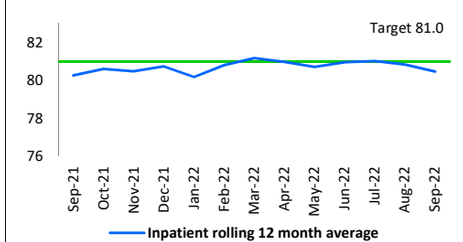
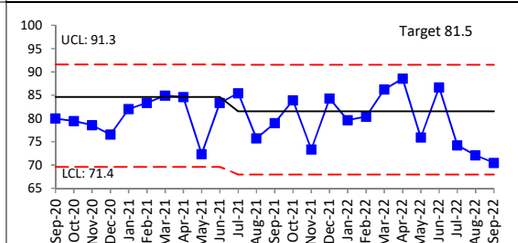
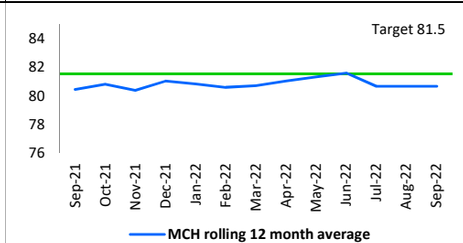
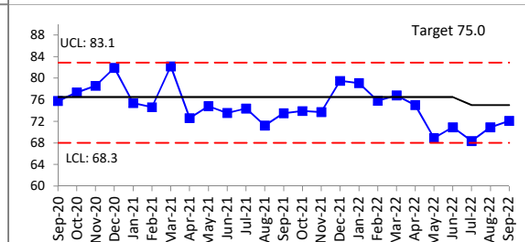
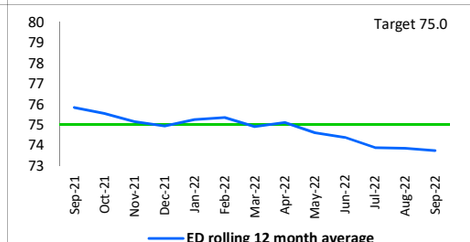
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

September 2022 (unless otherwise specified)

Month to Board Quality Committee:

November, 2022

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend *(showing at least the last 24 months of **available** data)*	FYTD or Rolling 12 Month Average	Measure Name
		Latest month	FYTD					
13	**Patient Throughput-Median Time: Arrival to ED Departure** *Latest data month: Sep, 22*	MV: 430 mins LG: 265 mins ENT: 348 mins	MV: 390 mins LG: 277 mins ENT: 334 mins	MV: 320 min LG: 259 min Ent: 290 min	MV: 304 min LG: 246 min Ent: 275 min			**Patient Throughput-Median Time from Arrival to ED Departure** (excludes psychiatric patients, patients expired in the ED, newborns, & transfer between sites
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Sep, 22*	75.0	79.9	80.8	81.0			**Inpatient Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted**
15	**IP MCH - HCAHPS Likelihood to Recommend, Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Sep, 22*	70.5	72.3	81.3	81.5			**Maternal Child Health - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted**
16	**ED Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: Sep, 22*	72.1	70.3	74.5	75.0			**ED - Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.'%, Adjusted**

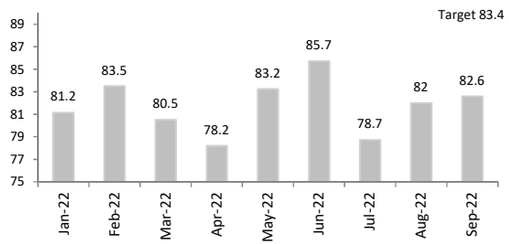
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

September 2022 (unless otherwise specified)

Month to Board Quality Committee:

November, 2022

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend (showing at least the last 24 months of ***available*** data)	FYTD or Rolling 12 Month Average	Measure Name
		Latest month	FYTD					
17	*** Organizational Goal** **ECHMD (El Camino Health Medical Network) : Likelihood to Recommend Care Provider** **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Unadjusted** *Latest data month: Sep, 22*	82.6	81.0	83.2	83.4		NA	**ECHMD (El Camino Health Medical Network) - Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted**

Notes:

1) SSER through Jul, 22

2) Readmissions through Aug, '22

3) PC-01 & PC-02 final results through FY22Q3; Q4 available after 11/1/22

4) ECHMD All: reflect new vendor (PG) survey results

Updated: 10/24/22

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
1	*Organizational Goal **HAC Index** *Latest data month: Sep, 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: Sep, 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: Sep, 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
4	HAC component **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: Sep, 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

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: Sep, 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: Sep, 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)** # of events/ FYTD rolling 12 month per 10,000 Acute Adjusted Patient Days *Rate* ****Latest data month: Jul, 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 For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HPI Systems
8	**Readmission Index (All Patient All Cause Readmit) *Observed/ Expected*** ***Premier Standard Risk Calculation Mode*** ****Latest data month: Aug, 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

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
9	**Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: Sep, 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, based on ICD-10 codes** *(Observed over Expected)* *Latest data month: Sep, 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: Mar, 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: Mar, 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	**Patient Throughput-Median Time: Arrival to ED Departure** *Latest data month: Sep, 22*		S. Singh	1) Same as CMS' ED Measure (ED 1b) "ED Arrival to ED Departure for Admitted pts. 2) Inclusions: patients who arrive via the ED 3) Exclusions: ED expirations, newborns, behavioral health patients & transfers between campuses. 4) Arrival: Patient Arrived in ED; ED Departure: Departed ED For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	iCare Report: ED Admit Measurement Summary
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Sep, 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
15	**IP MCH - HCAHPS Likelihood to Recommend, Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Sep, 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: Sep, 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

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
17	*** Organizational Goal** **ECHMD (El Camino Health Medical Network) : Likelihood to Recommend Care Provider** **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Unadjusted** *Latest data month: Sep, 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 Jul, 22

2) Readmissions through Aug, '22

3) PC-01 & PC-02 final results through FY22(

4) ECHMD All: reflect new vendor (PG) surv

Updated: 10/24/22

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: Cornel Delogramatic, MD, MBA, Director Clinical Documentation Integrity
Date: November 7, 2022
Subject: FY23 Clinical Documentation Integrity (CDI) Dashboard

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on the work of Clinical Documentation Integrity department.

Summary: Clinical Documentation Integrity (CDI) is integral to improving the accuracy of healthcare records/documentation to ensure improved patient outcomes, data quality and accurate reimbursement.

Situation: Our El Camino Health brand depends on the accuracy of the data recorded in our electronic medical record (EMR). Ratings organizations such as the Leapfrog Group, CMS Star Rating and HealthGrades rely on publicly reported data extracted from our EMR on over 30 national performance measures of patient safety and quality. In short, CDI and the work this team does, is foundational to our ability to provide exceptional care to our patients and community from the bedside to Washington D.C (CMS) where surveyors are tenaciously monitoring our performance.

Background: Monitoring and improving the deliverables of our CDI program relies on several measures. Seven of these measures are described in the attached CDI dashboard in the domains of; CDI span of coverage of patient insurance type, physician response rate and volume of documentation queries.

Assessment: The attached dashboard describes, in the comments section, a summary description of our performance on each of these measures.

Measure 6 and 7 describe the CC/MCC capture rate for medical and surgical patients. For review, here is a brief description of CC/MCC components and how they inform our 'case mix index':

The Inpatient Prospective Payment System (IPPS) methodology utilizes the major complication or comorbidity (MCC) and complication or comorbidities (CC) designation for specific ICD-10-CM codes to impact the relative weight (RW) of certain Medicare-Severity Diagnostic Related Groups (MS-DRGs). Identifying the MCC/CCs in the clinical documentation is a vital component to accurate code assignment and ultimately the accurate payment. Knowing when to query the provider documentation specificity and when to report the MCC/CC takes knowledge, skill and patience.

Those of us within the healthcare workforce who are dedicated to clinical coding and clinical documentation integrity (CDI) know that under the Medicare Inpatient Prospective Payment System for acute care hospitals the relative weight (RW) of the Medicare-Severity Diagnostic Related Groups (MS-DRGs) provides the case mix index (CMI) for the patient population. The RW is an indication of the resource consumption of a given diagnostic related group; the higher the RW, higher resources and higher costs, the higher the reimbursement for the given MS-DRG. This CMI can assist with estimating the payment the hospital can expect and is used to project Medicare reimbursement.

The major complication or comorbidity (MCC) and complication or comorbidity (CC) component of IPPS have a significant impact to MS-DRG RW and CMI and they have the following definitions:

- *A complication is a condition that arises during the hospital stay that prolongs the length of stay.*
- *A comorbidity is a pre-existing condition that affects the treatment received and/or prolongs the length of stay.*

The mere presence of a MCC or CC in a hospital inpatient encounter is usually a signal that the patient required and/or utilized more resources, which then can impact the MS-DRG and the associated RW. Therefore, hospitals receive a higher reimbursement (payment) for those patients with higher resources and/or utilization of care, with higher RW.

Obtaining the accurate MS-DRG takes complete, specific and thorough documentation followed by complete, accurate and compliant coding. Many of the MCC/CCs within IPPS are ICD-10-CM codes, which are very specific to capture severity and acuity. The greater the documentation specificity, the greater the coding specificity which then reflects the patient's condition for the MS-DRG and payment. ("MCC/CC Component of IPPS MS-DRGs" G. Bryant. August 202

List of Attachments Attachment 1—Clinical Documentation Integrity Dashboard through Q1 FY23

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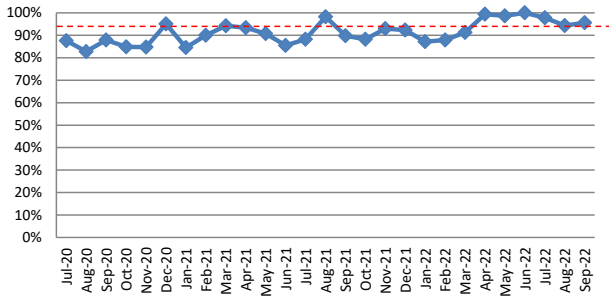
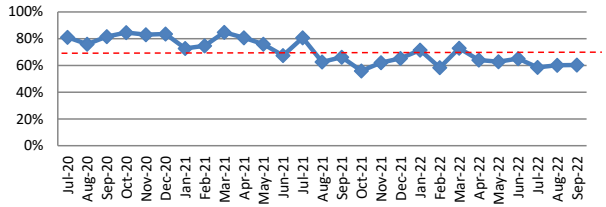
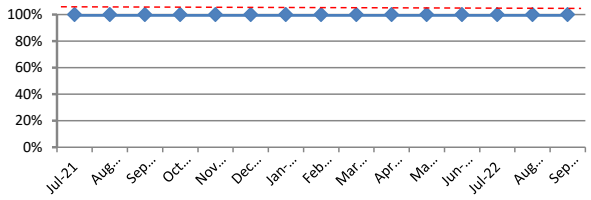
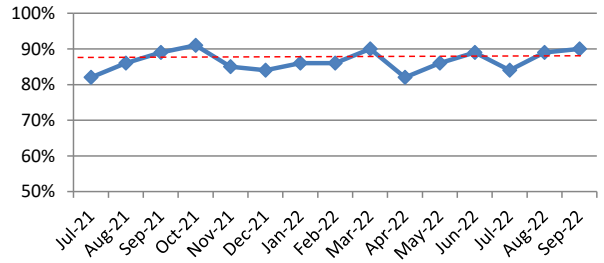
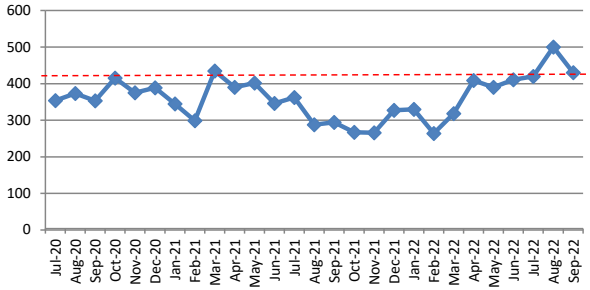
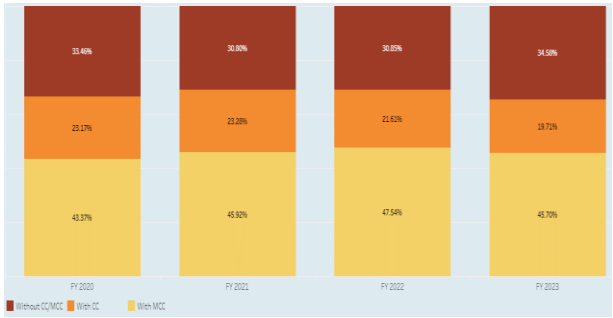
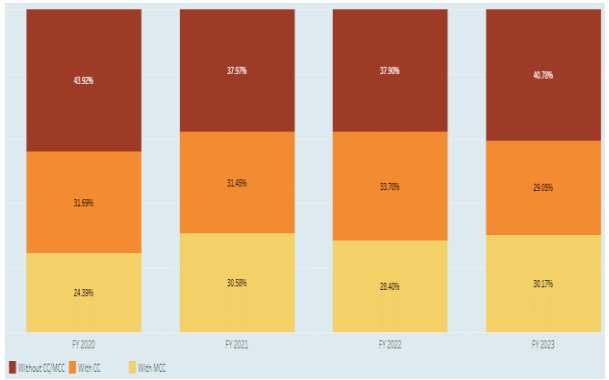
Clinical Documentation Integrity Dashboard (Monthly/ ALL adult, acute care, non-OB inpatient population)

As of Oct 28, 2022				Baseline	FY21 Goal	Trend	Comments
CDI Coverage		**Performance**		**FY2022**	**FY2023 goal**		
1	**Medicare** **Source: iCare CDI Productivity report*	**Sep 2022** 542/518 **96%**	**FYTD** **96%**	**93%**	**95%**		CDI team continues to prioritize Medicare accounts despite covering multiple additional documentation projects. Due to increased efficiency and planning Medicare coverage by CDI team did not suffer during CDI Outpatient expansion. The coverage rate remains at 91% FYTD slightly above the goal established for the fiscal year. After almost 2 years the team is fully staffed and working diligently to impact the quality, complinace and financial outcomes.
2	**All Payor** **Source: iCare CDI Productivity report*	**Sep 2022** 1617/977 60%	**FYTD** **60%**	**66%**	**70%**		The priority of the CDI department is to cover the entire Inpatient population, that benefits the quality scores a lot, at this time, due to short staff, priority was on Medicare and Medicare Advantage payers (DRG based) and the All-Payer coverage had a downtrend. With the addition of new staff in January, the numbers should start uptrending.
Physician Response		**Performance**		**FY2022**	**FY 2023 goal**		
3	**Query Response Rate** **Source: iCare CDI Query report*	**Sep 2022** **100%**	**FYTD** **100%**	100%	100%		The response rate remains 100% mainly due to solid adherence to Physician Query policy, escalation protocols, and robust physician engagement. The rate is the highest compared to similar programs around the nation. Epic has named El Camino Health in the top 25 Epic users nationwide with the highest physicians response rate.
4	**Query Agree Rate** **Source: iCare CDI Query report*	**Sep 2022** **90%**	**FYTD** **88%**	86%	89%		The agreement rate achieved for the second time ever recorded the milestone of 90%. There is a direct correlation between a lower number of queries and a better response rate. Nonetheless, I think the last results also have to do with the high visibility of the CDI specialists and the optimizations of the query templates that mainly contributed to the high response rate.

Queries volume			Performance		FY2022	FY 2023 goal		
#	5	**Query volumes** **Source: iCare CDI Query report*	**Sep 2022** **430** **44**% of of all reviewed accounts	**FYTD Avg.** **450** **45**% of all reviewed accounts	Queries Avg. **329**	Query 40% of all reviewed accounts		The query rate is scaling up mainly attributed to our new 2FTE additions in CDI staff and improving the efficency of the CDI workflows.
	6	**Medical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient) *Source: Tableau CDI Dashboard *Higher MCC/CC Capture Rate better reflects severity of population*	**Sep 2022** **MCC** 45% **CC** 21% **NCC** 34%	**N/A**	**Nat 80th% CMS 2018** MCC 48% CC 25% No CC 26%	**Nat 80th% CMS 2019**		The Medical CC/MCC continue to increase year over year, a reflection of an advance CDI program and a successful medical staff education around clinical documentation importance.
	7	**Surgical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient) *Tableau CDI Dashboard *Higher MCC/CC Capture Rate better reflects severity of population*	**Sep 2022** **MCC** 34% **CC** 29% **NCC** 38%	**N/A**	**Nat 80th% CMS 2018** MCC 28% CC 31% No CC 41%	**Nat 80th% CMS 2019**		Surgical cases make up 19-25% of our Medicare patient volume. The most significant impact on CMI, GMLOS, risk adjustment quality outcomes will be by increased Surgical CC/ MCC rate.

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EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Franz Encisa BSN MHA RN CPHQ
Director of Quality, Accreditation, Regulatory, Public Reporting
Date: November 7, 2022
Subject: FY 2022 Core Measure Dashboard for November Meeting

Purpose:

To update the Board on FY 2022 Core Measure Dashboard, Non-HBIP and HBIP.

Recommendation:

To approve this report.

Summary: 1. Provide the Committee with the current CMS and TJC required clinical core measure data results; 2. Annotation is provided to explain actions taken affecting each metric. 3. These core measure results are applied by CMS to several programs: CMS Value-based Purchasing program (VBP), CMS Star Ratings, Leapfrog Safety Grade, and Quality Incentive Pool (QIP) program.

1. Authority: The Quality Committee of the Board is responsible for the quality and safety of care provided to ECH patients. This dashboard provides oversight on compliance with CMS measurements of clinical quality.

2. Background: There are no revisions for FY 2022 by CMS or TJC to the core measures. Some metrics are measured as eCQM (electronic Clinical Quality Measure) reporting in accordance with CMS "Meaningful Use" program. Sepsis (SEP-1) Core Measure is reported as its own dashboard. These measures only reflects Inpatient Quality Reporting (IQR) and some Outpatient Quality Reporting (OQR) Program Measures.

3. Assessment: CMS has two sets of Core Measures: one covers acute hospitals and the second only applies to acute hospitals with inpatient behavioral health units, which is called HBIPS (Hospital-based Inpatient Psychiatric Services).

A. Non-HBIPS Core Measures

i. **PC-01 Early Elective Delivery (EED)** Prior to 39 weeks gestation - Percent of mothers with elective vaginal deliveries or elective cesarean births at >=37 and < 39 weeks gestation completed. MCH continues to prospectively track EED and reach out to providers to reschedule as needed. When an EED occurs and was seemingly not indicated primary provider is contacted and informed that we are tracking and request is made to closely monitor and avoid unindicated EED. FY22 ECH = 1.2%, vs TJC <=2%.

ii. **PC02- Cesarean Birth**- Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. Target goal of 23.9%; FY 2022 Performance is 25.8%. Of note, Leapfrog is following Healthy People 2020 NTSV cesarean birth rate target of 23.9% and 23.6% or less by 2030. OB Task Force is working to identify where we can make system improvements

to reduce unnecessary NTSV. MCH leadership team has worked with independent OBs and OB groups to identify practice patterns and opportunities for improvement. Each provider get their personal score card twice a year so they can see how they are doing along with their peers.

iii. **PC05- Exclusive Breast Milk Feeding**- Newborns that were fed breast milk only since birth during the entire hospitalization. ECH Target goal is 70%; FY 2022 Performance: 58.3% which is below target, but above TJC's rate of 50%. MBU has a taskforce committee for hand expressing breast milk. Lactation specialists provide information and support for breastfeeding patients. We offer outpatient consulting and a free drop-in support group. Los Gatos campus is a designated Baby-Friendly Hospital, recognizing that we offer an optimal level of care for breastfeeding mothers and babies. Nancy Held, RN, MS (Perinatal Clinical Nurse Specialist), IBCLC, joined the MBU team as the new manager for Lactation and Education Services (enterprise).

iv. **PC06- Unexpected Complications in Term Newborns**- this measure is intended to track moderate-to-severe adverse outcomes of healthy infants without preexisting conditions. Target goal is 0%; FY 2022 performance is 2.11% compared to TJC's 3%. The most common type of unexpected complication of a new born is related to transient respiratory distress.

v. **OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients**-Median time (in minutes) patients spent in the emergency department before leaving from the visit. Target goal is 180 minutes or less; FY 2022 rate is 180 minutes.

vi. **OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke**- Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival. Target goal is 100%; FY 2022 performance is 60%.

B. HBIPS Core Measures

i. **IMM-2 Influenza Immunization** Patients assessed and given influenza vaccination. Target goal is 100%; FY 2022 performance rate is 95%.There's a daily concurrent review of patients eligible for the influenza vaccine during flu season. For 2021-2022 flu season, an admission navigator flu vaccine workflow was implemented to streamline the process that helped frontline staff document efficiently. Care Compare (previously Hospital Compare) Reporting -IMM-2 Influenza Immunization- ECH is 97%; California rate 78%; National 79% Reporting period 10/1/2020 to 3/31/202

ii. **HBIPS-5 Patients Discharged on multiple antipsychotic medications with appropriate justification.** Target goal is 80% FY 2022 rate is 65%. Variances sent to MHAS team for further review and education to providers. This measure is part of OPPE.

iii. **PC-TOB Perfect Care - Tobacco Use**- ECH Target goal is 80%. FY 2022 rate is 43.2%. Variances sent to MHAS team for further review and education to providers. iCare modified tobacco order set to increase compliance. New Social workers were educated on tobacco counseling referral process. Quitline process is still efficient versus California Smoker's Helpline. Daily concurrent review of this measure includes participation of MHAS team – director, Manager, ACM/house supervisors, frontline staff and social workers.

iv. **PC-SUB Perfect Care - Substance Abuse**- Target goal is 80% FY 2022 rate is 92%.

v. **TR-1 Transition Record with Specified Elements Received by Discharged Patients next provider**. Target goal is 75%. FY 2022 rate is 86%.

vi. **MET-1 Screening for Metabolic Disorders** - Comprehensive screening currently defined to include: Body mass index A1C or glucose test Blood pressure Lipid panel Total cholesterol Low-density lipoprotein High density lipoprotein Triglycerides. Target goal is 75%; FY 2022 rate is 95%

vii. **HBIPS-2 Hours of Physical Restraint Use (per 1000 patient hours)** Target goal is 0.0004; FY2022 rate is 0.0002

viii. **HBIPS-3 Hours of Seclusion Use (per 1000 patient hours)** Target goal is 0.0003; FY2022 rate is 0.0003. ECH is within ECH-defined goal for hours of physical restraint and seclusion

4. Other Reviews: N/A

5. Outcomes: N/A

List of Attachments:

1. Attachment 1: FY2022 Core Measure Report Non-HBIPS for GB
2. Attachment 2: FY2022 Core Measure Report HBIPS for GB

Suggested Board Discussion Questions: None

El Camino Health

FISCAL Year 2022- HBIPS Core Measure Summary Report

Goal Near goal Below goal

Hospital Based Inpatient Psychiatric Services (HBIPS) Measure Name		ECH Goal	FY 2021	FY 2022													
				JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FY 2022	External Benchmark (IBM All Core Measures Hospital)
				2021						2022							
IMM-2	Influenza Immunization	100%	97.4%	Not Flu Season	Not Flu Season	Not Flu Season	95.1%	90.2%	98.4%	95.1%	93.4%	98.7%	Not Flu Season	Not Flu Season	Not Flu Season	95.32%	83.5%
HBIPS-5	Patients Discharged on multiple antipsychotic medications with appropriate justification	80%	71.2%	64.3%	75.0%	75.0%	56.3%	84.6%	50.0%	85.7%	55.6%	100%	62.5%	50.0%	75.0%	64.7%	62.5%
PC-TOB	Perfect Care - Tobacco Use	80%	23.7%	No cases	0.0%	0.0%	No cases	50.0%	50.0%	33.3%	33.3%	75.0%	28.6%	50.0%	45.5%	43.2%	41.3%
PC-SUB	Perfect Care - Substance Abuse	80%	92.8%	100.0%	100.0%	100.0%	0.0%	88.9%	75.0%	75.0%	100.0%	91.7%	100.0%	100.0%	100.0%	92.1%	64.7%
TR-1	Transition Record with Specified Elements Received by Discharged Patients	75%	91.7%	87.3%	85.7%	80.6%	89.2%	88.9%	81.8%	68.8%	83.3%	88.0%	92.3%	90.9%	90.7%	86.2%	60.7%
MET-1	Screening For Metabolic Disorders	75%	91.9%	98.0%	94.0%	98.0%	90.7%	94.1%	98.0%	100.0%	95.6%	94.3%	93.3%	92.5%	93.9%	95.0%	86.3%

El Camino Health

FISCAL Year 2022- HBIPS Core Measure Summary Report

Goal Near goal Below goal

Restraints and Seclusions		ECH Goal	FY 2021	FY 2022													
				JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FY 22	External Benchmark (IBM All Core Measures Hospital)
				2021						2022							
HBIPS-2	Hours of Physical Restraint Use (per 1000 patient hours) (lower=better) Numerator: The total number of hours that all psychiatric inpatients were maintained in physical restraint Denominator: Number of psychiatric inpatient days	0.0004	0.0005	0.0008	0	0.0001	0	0.0005	0.0003	0.0006	0	0	0	0.0002	0	0.0002	0.0001
			110.0333/239688	16.8333/20496	0/22368	3.8/25488	0.8333/23256	13.1833/25968	6.7333/24048	7.7667/13536	0/23088	0/20880	0/20328	5.5/23208	1.4833/30360		
HBIPS-3	Hours of Seclusion Use (per 1000 patient hours) (lower=better) Numerator: The total number of hours that all psychiatric inpatients were held in seclusion Denominator: Number of psychiatric inpatient days *Note: Event measures (HBIPS-2 and 3) are calculated by event occurrence date.	0.0003	0.0004	0.0002	0.0002	0.0001	0.0001	0.0018	0.0003	0.0007	0	0	0	0.0001	0.0002	0.0003	0.0003
			105.5/239688	3.4167/20496	4.4167/22368	2/25488	2.95/23256	46.3667/25968	7.5167/24048	8.9/13536	1.0333/23088	0.75/20880	0/20328	2.6333/23208	5.3833/30360		

El Camino Health

Goal Near goal Below goal

FY 2022 Core Measure Summary Report

Included in CMS Star Ratings: Included in Leapfrog:

Inpatient Measure name		ECH GOAL	FY 2021	FY 2022												FY 2022	External Benchmark (TJC)
				July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June		
				2021						2022							
PC-01	Elective Delivery Prior to 39 weeks gestation (lower =better)	0%	0.31% (1/321)	0% (0/39)	3% (1/33)	2.6% (1/39)	0% (0/35)	0% (0/24)	3% (1/29)	5.6% (1/18)	0% (0/20)	0% (0/25)	0% (0/25)	0% (0/31)	O% (0/38)	1.2 % (4/356)	2%
PC-02	Cesarean Section Rate (lower=better)	≤23.9%	26.1% (495/1900)	21.7% (38/175)	29.2% (55/188)	26.2% (53/202)	26.7% (55/206)	22.3% (46/206)	25.9% (54/208)	20.3% (33/162)	25.5% (47/184)	25.7% (52/202)	28.4% (52/183)	27.8% (51/183)	28.5% (50/175)	25.8% (586/ 2274)	25%
PC-05	Exclusive Breast Milk Feeding During Hospital Stay	70%	61.9% (456/737)	70.2% (52/74)	53.4% (31/58)	58.4% (45/77)	50% (41/82)	62.3% (48/77)	56.7% (42/74)	57.3% (39/68)	52.9% (36/68)	57.3% (43/75)	61.1% (41/67)	53.8% (42/78)	66.2% (47/71)	58.3% (507/ 869)	50%
PC-06	Unexpected Complications in Term Newborns(lower=better)	0%	1.6% (58/3642)	2.8% (10/354)	2.3% (9/383)	2.2% (9/399)	2.9% (11/378)	1% (4/378)	2.7% (10/368)	1.9% (6/313)	1.6% (6/361)	2.4% (9/375)	1.9% (7/352)	1.3% (5/380)	1.8% (6/320)	2.11% (92/4361)	3%

Outpatient Measure name		ECH GOAL	FY 2021	FY 2022												FY 2022	External Benchmark (CMS)
				July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June		
				2021						2022							
OP-18b	Median Time (in minutes) from ED Arrival to ED Departure for Discharged ED Patients (lower=better)	<180	173	167	181	178	174	167	191	181	177	181	203	172	189	180	98
OP-23	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival	100%	61.5% (8/13)	0% (0/1)	50% (1/2)	100% (1/1)	No Cases	0% (0/1)	No Cases	100% (1/1)	100% (1/1)	0% (0/1)	No Cases	100% (2/2)	No Cases	60% (6/10)	100%

Core Measures	*External Benchmark source- IBM Care Discovery Quality Measures July 2021- June 2022
Perinatal (PC)	TJC
Non PC	CMS Standard of Excellence-Top 10% of Hospitals

As of: 09/07/22

Quality Committee Follow-Up Items

Item	Date Requested	Committee Member Name	Item Requested	Completion Date
1	2/7/2022	Krutica Sharma, MD	Please add the definitions back onto the Enterprise Dashboard	3/7/2022
2	2/7/2022	Krutica Sharma, MD	Please include the Red Flags for the Medical Staff Credentialing Privileges Report	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.	
4	4/4/2022	Holly Beeman, MD	Update FY23 Quality Committee Goals to include: DEI, HRO	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.	8/1/2022
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.	9/7/2022
7	9/6/2022	Carol Somersille, MD	on the item dated 06/06/2022 to her name and remove Holly Beeman's name under Committee Member.	9/7/2022

Patient Experience Journal

Volume 9 | Issue 1 Article 2

Measuring what matters: A proposal for reframing how we evaluate and improve experience in healthcare

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Measuring what matters: A proposal for reframing how we evaluate and improve experience in healthcare

Cover Page Footnote

This article is associated with the Policy & Measurement lens of The Beryl Institute Experience Framework (https://www.theberylinstitute.org/ExperienceFramework). You can access other resources related to this lens including additional PXJ articles here: http://bit.ly/PX_PolicyMeasure

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Commentary

Measuring what matters: A proposal for reframing how we evaluate and improve experience in healthcare

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Abstract
The conversation on measuring experience has been a long and thoughtful one. It has reflected a dynamic tension between measures used as a lever for action in some health systems and as a mechanism to determine reimbursable dollars in others. Yet underlying all the conversation, the question of what we measure, to what end we measure and what truly matters to those who experience care remains. Through a series of conversations over the last two years senior experience leaders across healthcare organizations determined it is time to assess the current landscape of patient experience measurement, to acknowledge what the existing system of measurement has inspired in effort and outcomes and to look forward to what could really make a difference in providing actionable insight and sustainable improvement in the future. While there are policy requirements for what organizations measure and report along with financial implications, this need not be the universal means by which patient feedback is captured and issues are addressed. This is paralleled by a global call for a clear, simple, comparable and actionable system of measurement to both understand and improve experience efforts in healthcare. This article reflects those conversations and frames the opportunity we have. It acknowledges all that the current system of measurement has helped us do, offers a new view on what measurement can be and presents a call to action to convene a diverse range of voices to shape experience measurement for the future.

Keywords
Patient experience, human experience, experience measurement, HCAHPS, policy, Chief Experience Officer, CXO, benchmarking, innovation, global

It Is Time to Reframe How We Measure Experience

The conversation on measuring experience has been a long and thoughtful one. It has reflected a dynamic tension between measures used as a lever for action in some health systems and as a mechanism to determine reimbursable dollars in others. Yet underlying all the conversation, the question of *what we measure, to what end we measure and what truly matters to those who experience care* remains.

Through of a series of conversations over the last two years driven from the Experience Leaders Circle (XLC) of The Beryl Institute, actionable ideas have emerged. The XLC, representing senior experience leaders across healthcare organizations, felt it was time to assess the current landscape of patient experience measurement, acknowledge what the existing system of measurement has inspired in effort and outcomes and look forward to what could really make a difference in providing actionable insight and sustainable improvement in the future.

While there are policy requirements for what organizations measure and report along with financial implications, this need not be the universal means by which patient feedback is captured and issues are addressed. Across the Institute community, from the XLC to the Institute's Global Council and Patient & Family Advisory Board and beyond, there has been an aligned call for a clear, simple, comparable and actionable system of measurement to both understand and improve experience efforts in healthcare.

Foundational to these efforts has been the work of the Patient Experience Policy Forum (PXPF)[1] which has worked to bring together the voices of those who provide care in partnership with those who receive it to envision

and advocate for what measurement of the healthcare experience can and must be. PXPF has worked to raise new priorities for patient experience measurement, shared in two papers cited below, and is actively engaging with US policy makers to evolve measurement approaches. The work of PXPF provides the grounding from which an effective conversation on measurement can and will grow.

This article reflects these community conversations, actions and efforts and frames the opportunity we have. It acknowledges all that the current system of measurement has helped us do, offers a new view on what measurement can be and presents a call to action to convene a diverse range of voices to shape experience measurement for the future.

This is a pivotal moment in the experience movement. It is inspired by the realities of healthcare exposed by the pandemic, the speed with which healthcare organizations will be required to change and the clearly expressed needs of global citizens – as patients, care partners and consumers of the healthcare ecosystem. It is a time to move from reflection to action. Our hope is this discussion moves us forward with agility, purpose and intention. Those who experience healthcare today and in the future deserve no less.

The Opportunity at Hand

Feedback from patients and families is collected in various ways including, but not limited to, written letters, focus groups, patient and family advisory councils, phone calls, social media, narrative comments and surveys. Most organizations rely on traditional survey methods to assist in measuring, comparing and prioritizing improvement for the patient experience. Yet the existing approach has limitations and, more importantly, opportunities we should consider, including:

- **Limitations on Input.**
  - ***Measuring only episodes of care.*** Most survey instruments measure discreet episodes of care such as an office visit, hospital stay, emergency room visit or procedure. This misses the wider journey, including experiences between episodes, that can support systemic awareness, appropriate coordination of care and more comprehensive improvement.
  - ***Barriers to accessibility and understanding.*** Current data collection methods are hard to access for some and difficult to understand for others. Creating understandable and accessible measurement structures is key to ensuring equity and promoting the ability to address disparities.
  - ***Not including support networks.*** Most survey tools do not capture the experience of family members or care partners who are critical members of the care team.[2] The perspectives and needs of these individuals are important in helping to drive improvement and action but are often missed in current processes.
- **Inflexibility and Duplication.** The static nature of existing surveys does not allow for dynamic adaptation to the environment or understanding the longitudinal experience of a patient over time. This can result in survey fatigue, as patients are often asked to answer the same set of survey questions time and time again for various care encounters, and a loss of important feedback that could lead to more positive, actionable changes.
- **Length and Modes.** Surveys have increased in length due to both regulatory and accreditation requirements and the expansion of question sets by organizations aiming to address specific goals. Also, primary modes of mail and phone surveying hamper the ability to access and engage people to provide feedback. This has resulted in lower response rates and limits access to diverse voices.
- **Timeliness and Speed to Action.** Often the access to responses and associated analysis can take several weeks, and statistically significant accumulation of data can take longer. Teams working to understand and address immediate needs or test improvement interventions often struggle to correlate timing of their efforts to response data due to this lack of timeliness.
- **Benchmarking and Effective Comparison.** Current benchmarking structures lead to compression of data, as most healthcare organizations score well in terms of the absolute top box scores.[3] When benchmarks or percentile ranks are applied based on the distribution of these data, a small movement in an absolute score can result in large shifts in a percentile rank. These shifts can prove to be distracting or even demotivating to teams working to make improvements. Also, with the proprietary nature of some benchmarking groups and changes over time due to vendor transitions, real comparisons are often difficult to determine.[4]
- **Connection to Staff Experience.** Current survey instruments do not effectively capture the connection between the patient experience and

the staff/physician experience as supported by evidence.[5] They also miss the chance to identify the nuanced but critical elements of connection between patients and the care team. In addition, as the experiences of patients and staff are measured with different instruments often by different parts of an organization, it is difficult to align what the data show to reinforce the connection between the two and the actions needed to ensure comprehensive improvement.

Honoring the Foundational Work

In identifying the opportunity, it is important to acknowledge what the current system of measurement has accomplished. The development of more robust standardized measurement structures over the last two decades has helped achieve significant focus and action on addressing experience in healthcare. It captured the attention of leadership, put "experience" on the strategic map and ensured a focus on experience as an essential part of the healthcare conversation.

An underlying concern is that as the focus on experience measurement in its current state has expanded, it has often become about the measures themselves – the red, yellow, and green scores – versus the intent of what is being measured and the actions that are taken as a result. That is why we believe it is time to evolve how we look at and act on experience measurement.

With that framing, we reaffirm measurement as offered today has served its purpose and has helped to ensure focus and push action. It has catalyzed organizational commitment to experience, and this focus has had an impact. We also recognize that in some systems, such as in the US, the current policy-based measurement models will continue to be required, as they offer a point of standard comparison linked to financial incentives. But they need not be the only form of measurement organizations use as we move forward.

Even as we honor the foundational work, it is now time to reframe experience measurement for the future. We do so with some clear considerations for action:

- We seek flexibility to ask what really matters.
- We seek a better means to capture the qualitative patient voice.
- We seek more actionable data.
- We must create an understandable, accessible and inclusive process that ensures we can fully listen to and learn from our diverse populations.
- We must ensure a process that enables us to more effectively identify and address issues of disparity and reinforce inclusion.
- We want to spend less time checking boxes for rating organizations who use the current required data to measure us.
- We want better, easier, and more open ways to compare our data to identify and support action.

Reframing For the Future

We envision a measurement system that provides actionable information, leads to sustained improvement and is scalable, agile, accessible, equitable and affordable. Creating flexibility in how and when feedback is provided and working to broaden who provides feedback provides the opportunity to better identify and act on the needs of a diverse range of patients, family members and care partners and tackle health disparities. Several factors should be considered as we reframe for the future, including:

Focus on what matters to patients, family members and care partners to better understand and act on what is important to them. Forward-focused measurement efforts must commit to broad accessibility, providing a range of ways for people to communicate via the means they prefer, and seek to understand what really matters to patients, family members and care partners.

- Language preferences should be considered, and the creation of new processes should use culturally sensitive design approaches.
- Alternative survey modes offering a range of feedback channels, beyond mail and telephone, should be employed to enhance completion rates.
- Experience measures must be expanded to capture more than quantitative ratings to include the gathering and analysis of patient narratives.[6]

Reconsider survey structures and processes to lessen the burden, increase timeliness and ensure broad applicability. Modernizing the structure and design of surveys is key to improving experience of patients, family members and care partners as well as the team members who care for them.

- Measurement efforts must work to remove bias and strive to engage a diverse range of voices that can both access and actively participate in the survey process to ensure representative samples.[7]
- Short, dynamic, comparative question sets should be established to support the collection of targeted, meaningful and actionable insights to enable leaders to apply timely interventions and provide opportunities for open comparison and shared learning.
- Opportunities to act on feedback at the individual level should be established to rapidly acknowledge and address patients, family

members and care partners' needs, positively impacting quality outcomes and the health and well-being of patients.

Establish more effective and meaningful avenues for benchmarking to support expanded accountability, drive clear action and foster broad-based learning and improvement. A contemporary approach to comparison must be open and easy to access and act on.

- Simple, co-created and commonly accepted and shared measurement frameworks will allow for more open, active, and timely data sharing both internally for immediate local improvements and externally to reframe traditional benchmarking approaches.
- An openness and commitment to sharing data, lessons learned, and practices implemented will foster a collaborative environment and drive broader organizational and systemic improvements.
- Sharing comparable data from a modernized measurement approach will provide transparency, reinforce community accountability and support decision-making for healthcare organizations, patients, family members, care partners and healthcare consumers.[4]

A Commitment to A New Future for Measurement

This modernized approach to listening to and acting on the feedback of patients, family members and care partners will lead to improved systems, quality outcomes and human- centered experiences. This needed evolution will require active participation, collaboration and cooperation from all key stakeholders.

We call for a collaborative coalition of voices from across the global healthcare ecosystem - from patients, family members and care partners to healthcare professionals, vendors and measurement experts **- to convene and commit to co-design the future together**. In considering the realities and opportunities outlined here, there is a clear opportunity to redefine how experience is measured – beyond current required processes – in a way that matters and is practical, accessible and actionable for all. In doing so, we must continue to consider:

- The accessibility and inclusivity of any measurement method
- The ability, time and convenience of those we are asking to provide feedback
- The impact on those who are tasked to act on what we learn
- The investment in time and resources of administering any measurement process

In moving this commitment forward, we will champion:

- **Collaboration with national policy forums and regulatory agencies:** Over the past decade and a half, the role of the experience leader has gained prominence across healthcare organizations. This is in large part due to the needed attention and focus on patient experience created through data transparency. Experience leaders have knowledge and understanding around the design, administration and application of current methods and tools and are eager to share their learning and perspectives and be active participants in the measurement system of the future.
- **Sharing of learning and experiences across organizations:** Experience leaders around the country and the globe have found a community to share learning from the frontlines, especially during the challenging times of the pandemic. Leaders are committed to sharing individual and collective experience of the measurement modernization journey alongside patients, families and colleagues.
- **Engaging leaders across all stakeholder groups:** The future of measurement presents the opportunity to engage leaders from the executive suite, boardroom, vendor community, rating agencies and regulators. It must be inclusive of patients, family members and care partners and open to external perspectives on what supports the best in experience measurement. As the healthcare landscape is changing and the industry is evolving, conversations among these groups will need to evolve as well.

A Call to Action for Key Stakeholders

In understanding the opportunity we have, acknowledging the foundations of this work and looking to a future we can co-create, there are key stakeholders who will play a pivotal role in moving these ideas to action. We call on each of these groups to consider how to join individually and collectively in moving this effort forward.

For Experience Leaders/Champions. Utilize understanding and experience with the current framework to understand the organization's current state and engage in discussions about future vision.

For Healthcare Leaders/Administrators. Recognize that patient experience is a strategic differentiator. This is true more than ever in the current dynamic healthcare environment, and the measurement system must evolve to meet the challenge.

For Policy Makers. Invite patient experience leaders and patient advocates to the table to discuss policy changes impacting the next generation of healthcare policy.

For Measurement Vendors. Co-develop and innovate with experience leaders on what the future of measurement can look and feel like – the start of true user research into designing measurement capabilities of the future.

For Payor/Insurance Organizations. Partner with patient and healthcare organizations, patients, family members and care partners and their members directly to understand the role of patient experience in creating value for patients and members.

For Accrediting Organizations/Rating Agencies. Evolve methodologies beyond traditional measures to create better alignment in improving experience and outcomes for patients.

For Patients & Family Members/Care Partners. Use this document to reinforce you are not simply subjects to what measurement looks to discover, but rather you are essential to the design of what effective measurement can and must be for the future.

We also encourage you to review *Using This Article for Action* below.

An Invitation: Co-Creating A Global Experience Measurement Set

With all that each of these groups can do distinctly, there is much more we must do collectively in our commitment to the future of measurement. In our call for a collaborative coalition of voices from across the global healthcare ecosystem to convene and commit to co-design the future together, we believe there is an opportunity to consider a new, shared, global measurement set that provides consistency, alignment, responsiveness, accessibility, effective comparison, focused action and shared learning.

Our intention is clear: to ensure a well-defined, actionable and representative means for measurement that both honors current requirements and leads us forward in a way that we can effectively and easily compare, share, learn and act on across organizational, system and national boundaries.

Now is the moment for action to ensure we not only listen but also act in a way that benefits our entire healthcare community. In the last two years, our global healthcare ecosystem has been challenged in ways we could have never imagined. Now is our chance to act as one in building a future for expanded listening, shared learning and ongoing improvement. We invite you to join us.

Using This Article for Action

A call to action is only as valuable as the ways in which it encourages movement. To support the application of this article and its intent to catalyze conversation and inspire effort, we offer the following considerations on how to use this document personally, in your organization and in the community. This article can serve as:

1. Personal talking points for conversations on measurement improvement. The key points laid out in the paper can be used as key talking points for how you personally address this topic in your organization.

2. A conversation starter with organization leadership. This paper can serve as a context- setting conversation starter with leadership and others for how your organization can and will address the opportunities of experience measurement moving forward with a commitment to drive improvement and realize better outcomes.

3. A position paper for policy makers and leaders. The broader premise of this paper can be shared in conversations with policy makers at local, national and global levels to introduce new perspectives, engage in new thinking and advocate for new directions for measurement locally and globally.

4. Context for an international conversation on developing a global experience measurement set. This paper will help frame a conversation on the potential development of a global experience measurement set to be co-produced from voices around the world and across the healthcare ecosystem.

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Acknowledgement And Support

The paper comes from a year-long dialogue among members of The Beryl Institute's Experience Leaders Circle (XLC) which is comprised of Senior Experience Leaders from a wide range of healthcare systems. The conversation identified the key action items and recommendations outline above. The full membership of the XLC listed below and the lead authors on this document stand together in offering their public support for this call to action.

Stephanie Abbott, *Chief Experience Officer, Adventist Health*
Helena Ackerson, *Vice President of Patient Experience, MaineHealth*
Kimberlee Alvari, *Chief of the Patient Experience, Washington Hospital*
Jennifer Jasmine Arfaa, *Chief Patient Experience Officer, UC Health*
Steve Basilotto, *Chief Experience Officer, Froedtert Health*
Vishal Bhalla, *Enterprise CXO/Market CHRO, Atrium Health*
Nicole Cable, *Chief Experience Officer, CareMax*
Brian Carlson, *Vice President, Patient Experience, Vanderbilt University Medical Center*
Megan Chavez, *Vice President, Patient and Family Experience, Cook Children's*
Christine Cunningham, *Chief Experience & Improvement Officer, El Camino Health*
Elizabeth Garcia, *Vice President, MD Anderson Cancer Center*
Sven Gierlinger, *Chief Experience Officer, Northwell Health*
Pam Guler, VP, *Chief Experience Officer, AdventHealth*
Suzanne Herman, *System Executive Director, Patient Experience, UNC Health*
Lori Hulse, *Vice President of Clinical Operations, Lehigh Valley Health Network*
Brenda Johnson, *Vice President, Patient Experience, University of Maryland St. Joseph Medical Center*
Marie Judd, *National VP, Patient and Care Team Experience, Ascension*
Cristobal Kripper, *System Director, Chief Experience Officer, CHRISTUS Health*
Steve Maffei, *VP, Org Effectiveness and Patient Experience, Methodist Health System*
Julie Oehlert, *Chief Experience Officer, Vidant Health*
Tony Padilla, *VP, Patient Experience, City of Hope*
Jennifer Purdy, *Executive Director, Veterans Patient Experience, Veteran's Health Administration*
Denise Schoen, *Chief Patient Experience Officer, Baystate Medical Center*
Marisa Schwartz, *Sr. Medical Director Patient Experience, St. Luke's University Health Network*
Jo Anne Thomson, *Vice President Patient Experience, University of Maryland Upper Chesapeake Health*

Appendix 1. Perspectives from the Field

This is a call to action to actually do what measuring patient experience is about – putting our patients and caregivers at the center of what we do and designing a system the revolves around them.
Stephanie Abbott, *Chief Experience Officer, Adventist Health*

This call to action truly focuses on the importance of putting patients, families and team members first by understanding their needs and wants, listening to their concerns and feedback and empathizing with their experiences.
Jennifer Jasmine Arfaa, *Chief Patient Experience Officer, UC Health*

The need to democratize data is pivotal to understanding our patients and their families to improve the human experience.
Nicole Cable, *Chief Experience Officer, CareMax*

This is an important reminder that we are in the business of caring, and given the complexities of health care delivery, we continue to need comprehensive and broad feedback from those we serve.
Brian Carlson, *Vice President Patient Experience, Vanderbilt University Medical Center*

Our hearts and minds have been opened to the reality that the patient experience is the human experience for all stakeholders – patients, families, caregivers, healthcare providers in every role. The current measurements are limiting our ability to be impactful. We must act now to change the course of healthcare experience for all.
Elizabeth Garcia, *Vice President, Patient Experience, MD Anderson Cancer Center*

Albert Einstein said, "We cannot solve our problems with the same thinking we used when we created them." Now is the time to think outside the box and truly leverage data measurement at a human experience level.
Brenda Johnson, *Vice President, Patient Experience, University of Maryland St. Joseph Medical Center*

We have an opportunity to truly listen to the voice of those we serve in new and more meaningful ways. By moving towards more real-time measures, shorter form survey processes, coupled with an ability to better understand the end-to-end journey - we will be able to better serve our communities in a more seamless and personalized way.
Marie Judd, *National VP, Patient and Care Team Experience, Ascension*

Effective measurement programs can help operational leaders drive change in the right direction and even face less resistance when implementing change because team members heard it coming from the patients' voice. Innovation in this area must become more nimble and more centered around the real needs of our patients.
Cristobal Kripper, *System Director, Chief Experience Officer, CHRISTUS Health*

As we continue to process the impacts of the pandemic and the pre-existing societal problems that it magnifies, the healthcare field must re-focus on the voice of our patients and caregivers to determine what truly matters. We must radically rethink how we deliver and measure optimal experiences. This proposal represents a clarion call for action.
Steve Maffei, *VP, Org Effectiveness and Patient Experience, Methodist Health System*

This is a call to action for all parties to lean in to determine how best to measure the "sum of all interactions" across the person(s) continuum of care to truly understand one's experience and to give qualitative data the respect it deserves.
Denise Schoen, *Chief Patient Experience Officer, Baystate Medical Center*

We have an opportunity to optimize the measuring process with keeping the patients' needs at the core of it all while ensuring healthcare teams are given meaningful data that they are able to act on to make positive improvements to their patients' care.
Marisa Schwartz, *Sr. Medical Director, Patient Experience, St. Luke's University Health Network*

Every story has power. Power to inspire, influence and change all of us as individuals and collectively within our organizations and systems. It drives our decision-making and therefore must be complete, accurate and insightful. The recommendations in this paper allow us to evolve in much needed ways, not just in our own organization but collectively to better the human experience.
Megan Chavez, *Vice President, Patient and Family Experience, Cook Children's*

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, DiplACLM
Date: November 7, 2022
Subject: Patient Experience E-Mail/Letter

Purpose: To provide the Committee with written patient feedback that is received via a letter from a patient's family member who had recently experienced care at El Camino Health Cancer Center.

Summary:

1. Situation: These comments are from a patient's family member who has received care at the El Camino Cancer Center. The comments are mostly related to the staff who made a positive impression especially in coordinating very complicated cancer care. The nurse mentioned often is the Cancer Center nurse coordinator.
2. Authority: To provide insight into a cancer patient's experience with ECH cancer center.
3. Background: This letter was written by the patient's daughter who wanted to express the communication and responsiveness of our Cancer Center staff.
4. Assessment: The letter reflects back all the training we have done with staff and physicians on the We Care Standards. The family noticed the way in which the patient was greeted, how clinical information was communicated, to the way in which communication was delivered—with compassion and empathy. And, significantly important was the notice of care coordination that was provided by the staff which can be so complicated especially when facing a cancer diagnosis.
5. Outcomes: The family was very pleased with the care and communication provided to her mother---a true reflection of the standards of excellence at the ECH Cancer Center.
6. List of Attachments: See patient letter.

Suggested Committee Discussion Questions:

1. How do you share positive feedback with the staff involved as well as recognize the entire program?
2. What training do you provide to staff on We Care standards and do the Cancer Center staff have the same training program as other staff in the enterprise?

[redacted]

September 30, 2022

Markettea Beneke
El Camino Cancer Center
2505 Grant Rd
Mountain View, CA 94040

Re: Roksaneh Larijani

Dear Ms. Beneke:

I wanted to take this opportunity to let you know that we are extremely impressed with the level of care from Roksaneh and El Camino Cancer Center.

My mother, [redacted] was diagnosed with breast cancer on June 24, 2022. As you can probably imagine, the diagnosis rocked our whole world. I don't think that I got more than a couple of hours of sleep the first several days because I was so worried and concerned. She had a mastectomy at the end of July. Post surgery, her surgeon, Dr. Miller referred her to Dr. Singhal and the Cancer Center at El Camino.

During our first appointment, we were immediately greeted by Dr. Singhal and Roksaneh Larijani. They were both so caring and compassionate. I expressed to Dr. Singhal and Roksaneh our anxiousness and our desire to get more information about my mom's pathology results and the steps going forward. Roksaneh will probably never know how appreciative my mom and I are to her for everything that she has done and continues to do for us. She has been a god-send to us. From our first visit with her, she was patient, understanding, and compassionate. She took the time to explain to us the various options available, provided us with guidance throughout my mom's ongoing treatment. She immediately puts us at ease with her calm demeanor, and she always take the time to answer our questions. We never feel rushed and we always leave our meetings with the knowledge and sense that she is doing everything she can. She responds to my emails and calls immediately and takes care of any issues with a bright smile and a compassionate heart. I cannot count the number of emails that I have exchanged with her since just last month about the various issues that have come up in my mother's treatment. She has provided education as well as coordination

of care and support for my mom's specific need. What has really stood out for me is the fact that she reaches out to us and informs us about updates on pending test results, insurance issues, or coordination of care. She is an amazing nurse and should be acknowledged for the exceptional level of care that she continues to provide to her patients. I honestly cannot imagine going through this difficult time without the support and guidance that Roksaneh has provided to us.

The cancer center has some other amazing individuals who deserve to be noted. Individuals like Maria Ramirez from the front desk who always greets you with a smile, to your social worker, Hope Porcia who assisted my mom during her first chemo session, to the nurses in the infusion center who are friendly, compassionate, and helpful. Some of the individuals who stand out have been Irina Pinili, Nancy Vick, Kathy Baity, Isagani Mabilin and Maridel Liang. Thank you for the excellent care that you and your staff continue to provide to my mother.

If you have any questions or concerns, please do not hesitate to contact me at [redacted]. Thank you.

Sincerely,

[redacted]

[redacted]

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: El Camino Hospital Quality Committee
From: Ken King, CAO
Date: November 7, 2022
Subject: FY-22 Annual Report – Evaluation of the Environment of Care & Emergency Management

Recommendation(s): The Safety Committee and the Emergency Management Committee of the Hospital recommends that the Board Quality Committee approve the Annual Report, Evaluation of the Environment of Care & Emergency Management.

Summary:

1. Situation: Despite the challenges presented by the lingering effects of the global pandemic, the management of the environment of care, the safety program with all its elements and the emergency management plan produced solid results. Highlights include:

a) **Employee Safety:** Focused effort to reduce Safe Patient Handling and Mobility (SPHM) injuries resulted in a decrease from 49 in FY-21 to 37 in FY-22 for a 25% reduction. Despite these positive results the total number of OSHA recordable injuries increased 8% over the prior year, however we maintained a low rate of lost work time injuries (0.9 per 100 FTE's) consistent with the last four years.

b) **Security:** Last year we had reduced the number of OSHA reportable Workplace Violence incidents 16% from the prior year, in FY-22 the number of Workplace Violence incidents was reduced 37% from FY-21. The decrease in incidents is attributed to enhanced Nonviolent Intervention training for staff in high-risk departments.

c) **Hazardous Materials:** There were no Reportable Hazardous Material Incidents or Waste Water Discharge violations.

d) **Fire Safety:** There was one fire incident in the MV MRI suite due to a monitor failure during FY-22. Staff responded appropriately and extinguished the fire without impact to patient care. All similar monitor models were immediately removed from service and replaced. Increased education efforts to improve staff knowledge regarding location of pull stations and fire extinguishers and horizontal and vertical exit pathways was successful with 98.7% positive responses during drills.

e) **Medical Equipment:** The planned maintenance for high-risk medical equipment was maintained at 98% completion rates, a 10% improvement over the prior year.

f) **Utilities:** There were three PG&E electrical power outages during FY-22, one in Los Gatos and two in Mountain View. All emergency power systems functioned as designed and there were no negative outcomes. Preventive maintenance completion rate on all critical utility system elements was 98%.

g) **Emergency Management:** Two successful Emergency Management Drills were conducted in FY-22. A drill testing our readiness for a large earthquake with a

countywide drill in October 2021 and a second countywide drill testing our readiness for a surge related to a mass shooting event in May 2022.

Overall, a positive outcome for the year, however, the incidents that occur in other cities throughout the country continue to affect the perspective of our staff. Shooting incidents in hospitals and other public facilities prompts us to reassess our training and preparation. To that end, we have engaged a qualified firm to conduct an assessment of our physical environment and to conduct active shooter training sessions with staff in high risk departments. We are also updating our training modules for all staff, contractors and volunteers.

1. Authority: Policy requires Quality Committee Approval of this report annually to maintain compliance with Joint Commission and CMS standards.

2. Background: This report is a required element for compliance with Joint Commission and CMS standards annually.

3. Assessment: The individuals, work groups and committees that oversee the elements of the Environment of Care, Life Safety and Emergency Management continue to follow a continuous cycle of improvement. The Joint Commission survey conducted in April 2022 validated the work being done to ensure a safe environment of care.

4. Other Reviews: This annual evaluation has been reviewed and approved by the Central Safety Committee and the Emergency Management Committed.

5. Outcomes: This annual report has been utilized to prepare updated management plans for each work group and committee for FY-22.

List of Attachments:

1. Full Report – Evaluation of the Environment of Care & Emergency Management

Fiscal Year 2022 Evaluation of the Environment of Care and Emergency Management

Prepared by:

Matt Scannell
Director, Safety and Security

Daniel Peck
Manager, Environmental Health and Safety

Created: 07/14/2022

Table of Contents

Program Overview

The Joint Commission (TJC) standards provide the framework for the Safety Program for Managing the Environment of Care Program, Emergency Management and Life Safety at El Camino Hospital. These programs meet the State of California requirements for an Injury and Illness Prevention Program (IIPP). It is the goal of the organization to provide a safe and effective environment of care for all patients, employees, volunteers, visitors, contractors, students and physicians. This goal is achieved through a multi-disciplinary approach to the management of each of the environment of care disciplines and support from hospital leadership.

The Central Safety Committee and Hospital Safety Officer develop, implement and monitor the Safety Management Program for the Environment of Care, Emergency Management and Life Safety Management. Reporting is completed as required for Joint Commission compliance.

The Central Safety Committee membership consists of the chairperson of each Work Group, and representatives from Infection Prevention, Clinical Effectiveness, Radiation Safety, the Clinical Laboratory, Employee Wellness and Health Services (EWHS), Nursing, Safety / Security and Human Resources.

Work Groups are established for each of the Environment of Care sections. They have the responsibility to develop, implement and monitor effectiveness of the management plan for their respective discipline. The status of each section is reviewed at the Central Safety Committee meeting and reported on the Safety Trends. The Safety Officer is accountable for the implementation of the responsibilities of the Central Safety Committee.

The Emergency Management Committee has the responsibility to develop, implement and monitor the effectiveness of the emergency preparedness program of El Camino Health. The committee provides a summary of activities to the Central Safety Committee on a quarterly basis.

The Central Safety Committee chairperson is responsible for establishing performance improvement standards to objectively measure the effectiveness of the Safety Program for Environment of Care.

The following annual review analyzes the scope, performance, and effectiveness of the Safety Program and provides a balanced summary of the program performance during fiscal year 2022. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer-term.

Executive Summary

Safety Management

Key indicators were identified to establish goals for FY22 with opportunities to improve Safety Management within the Environment of Care.

FY 22 Goals

1. R Safe Patient Handling and Mobility (SPHM) Injuries Analysis

Injury Rates: The rate of OSHA recordable SPHM injuries per 100 FTEs held steady in FY-22 at 1.0 compared to FY-21.

Total Injuries: The total number of SPHM injuries decreased from 49 in F/Y21 to 37 in F/Y22 for a 25% reduction.

2. Key indicators were identified to establish goals for FY22 with opportunities to improve Safety Management within the Environment of Care.

FY 22 Goals

EOC Area	Indicator	Responsible Dept./Function	Target
Safety	**Reduce employee injuries related to slips/trips/falls**	**EWHS /EH&S**	**Reduce employee injuries related to falls by 15%**

This goal was accomplished. In FY22, **we reduced employee OSHA Recordable lost time injuries related to slips/trips/falls by 63%. In FY22**, we had seven injuries related to slips/trips/falls compared to 19 in FY21.

Security Management

Effectiveness

Key performance indicators were identified in the FY22 to improve Security Management within the Environment of Care.

FY22 Goals

1. 90% non-medical emergency security response time less than 3 minutes.

   This goal was met

2. 15% reduction in number of reportable workplace violence incidents. In FY22 there was a 37% decrease in the number of Workplace Violence reports submitted to CAL-OSHA.
   This goal was met.

3. Reduce the number of reported thefts on both campuses by 10% over FY21 totals- (4) In FY22 there were total of 6 reported thefts (4 in MV and 2 in LG)

   This goal was not met.

Hazardous Material Management

Effectiveness

Staff training on hazardous materials is completed through computer-based training modules and is reported by the Safety Management Work Group. In addition, representatives from all areas represented in the Hazardous Materials Work Group completed a 40-hour HAZWOPER[1] training course.

Key indicators were targeted to establish goals for FY22. The following goals presented opportunities to improve hazardous materials & waste management.

FY22 Goals:

1. Review and revise the Hazardous Waste Stream Identification Policy and Hazardous Waste List attachment with an emphasis on Stakeholder Department's Hazardous Waste identification and handling through assessment, education providing accurate Hazardous Waste stream list.

   Measurement of success:

   i. 100% Completion review of Stericycle El Camino Health's 2021 Waste Stream Report followed by Gap assessment by Stake holder departments.

   ii. 100% Completion of education to appropriate staff of Stakeholder department, based on gaps identified.

   iii. 100% Completion of report of Hazardous Waste list per department.

   iv. 100 % Completion of updated attachment of the Hazardous Waste stream list to the Hazardous Waste Stream Identification Policy**.**

   This goal was partially accomplished-75% of goal accomplished

   Updated list (# iv., above) not complete, waiting for outside consultant to advise on Hazard Class and method of disposal for each waste before updating policy online.

2. Review and re-educate CsRX usage per regulatory standards, collections and communications for full container swap out for exchange. Joint Commission Mock

[1] HAZWOPER: Hazardous Waste Operations and Emergency Response

Survey identified a gap of nursing continuing to pour controlled substances into the CsRX container after container had reached capacity resulting in unsafe conditions.

a. **Measurement of Success**:

i. 100 % completion of flyer created by Education Department

ii. 100 % completion of Electronic Distribution of Educational Flyer to Clinical Staff.

iii. 100% completion of Posting Flyer near all CsRX containers

iv. Successful Joint Commission Survey with full compliance on CsRx Containers and usage.

This goal was accomplished – 100%.

Fire Safety Management

Effectiveness

Based on opportunities for improvement identified in FY21 annual EOC evaluation the FY22 Performance Improvement Indicators were as follows:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Fire Prevention	Staff knowledge of the nearest fire extinguisher and fire pull station.	Engineering, Security and Department Managers	>90%	**100%**
Fire Prevention	Staff knowledge of the emergency telephone number 55	Engineering, Security and Department Managers	>90%	**99%**
Fire Prevention	Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	>90%	**97%**

Note: We will choose all new indicators for FY23 due to staff performance in FY22.

Medical Equipment

Effectiveness

FY22 Performance Indicators

1. Improve the confidence level of the active assets in the inventory to greater than 90%.
   - **Measurement of Success**: Currently we are at an 84% confidence level of assets active in the database. This will be accomplished by tracking scheduled work orders on an asset by various sub status codes to assure the asset is a valid active asset and should remain in the inventory.

- **This goal was accomplished**. We reached and exceeded our goal. Through a process of identifying, documenting and communicating with department for assistance in locating assets in the database we were able to able to attain a 95% confidence level in our inventory.

2. Develop two network indicators that will alert potential monitoring network failures.
   - **Measurement of Success**: These indicators will provide solutions to preemptively resolve potential issues within the networked monitoring system. Previously, we only had Philips HL7 as an alert but in collaboration with Philips interface engineer and our hospital interface engineering, there were rules put in place to notify us with 15 minutes of inactivity.
   - **This goal was accomplished**. We setup an alert for our interfaces where various IT team members and Clinical Engineering members get notified via email for the following interfaces to preemptively resolve any networking issues affecting patient care;
     - Philips ADT Philips HL7
     - Philips VS30 Communication
     - Philips Intellispace HL7
     - Philips Intellispace ADT

Utility Systems

Effectiveness

Key indicators were targeted to establish goals for FY22. The following goals presented opportunities to improve Utility Management within the Environment of Care:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Utility Management	Staff can describe the proper way to store oxygen cylinders along with the amount per smoke compartment	Engineering, Security and Department Managers	>90%	100%
Utility Management	Staff can describe who has the authorization to turn off medical gas controls.	Engineering, Security and Department Managers	>90%	100%

Emergency Management

A. Effectiveness

Key indicators were targeted to establish goals for FY22. The following goals presented opportunities to improve emergency management.

FY-22 Goals

1. Expand the use of mass notification system (Everbridge) to all employees (continued from FY21)

- **Measurement of Success**
  - Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.
  - Evaluate and set up logical groups and rules for notifications.
  - Train key staff to be able to use/send alerts
- **This *goal was accomplished.***
  - All employees with Workday accounts are now included in a nightly update of the Everbridge database.
  - Groups are set up to allow custom notifications by campus, department, job classification, and geographic location.
  - Call Center staff are being trained on the use of Everbridge to allow for rapid notifications as needed.

2. Incorporate and expand emergency exercises in the new facilities at El Camino Health – Los Gatos Cancer Center, Taube Pavilion, Sobrato Pavilion, and Willow Outpatient Surgery.
   - ***This goal was accomplished.*** All exercises have been expanded to include all pavilions in planning and participation.
3. Revise Hospital Surge Plan.
   - ***This goal was accomplished.*** The Hospital COVID-19 Pandemic Plan was used as a reference to revise the Hospital Surge Plan. The plan was reviewed and approved by the Emergency Management Committee.

EC 1.0 - Safety Management

Work Group Chair: ***Mari Numanlia-Wone***

Scope: Safety Management is the responsibility of hospital leaders and every employee is responsible for the safe environment of care. Departments that have a specific role in the promotion and management of a safe environment may include, but are not limited to the following functional areas:

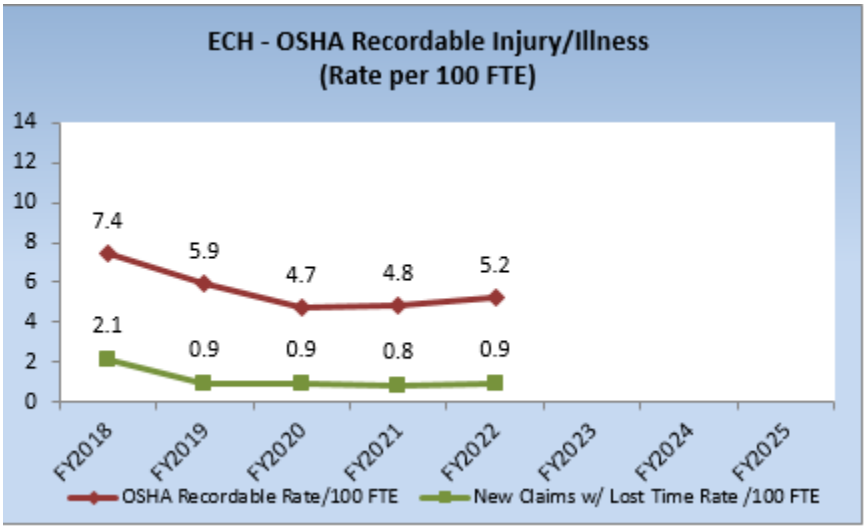
- Employee Wellness & Health Services
- Education Services
- Quality and Patient Safety
- Infection Prevention
- Security Management
- Environmental Services
- Facilities Services
- Patient Care Services
- Human Resources
- Radiation Safety

Performance: Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY22. This includes data from both the Mountain View and Los Gatos campuses.

[See Employee Health Services Definitions for a definition of terms and formulas used to calculate in this report.]

A. OSHA Recordable Injury & Illness

The rate of OSHA recordable incidents per 100 FTE **slightly increased in FY22 to 5.2 as compared to 4.8 in FY21.** The total number of recordable incidents increased to 145 compared to 131 in FY21.
The rate of lost workdays for all open claims (per 100 FTEs) **increased to 0.9 in FY22 compared to 0.8 in FY21. This low rate has been consistent in the last 4 years.**

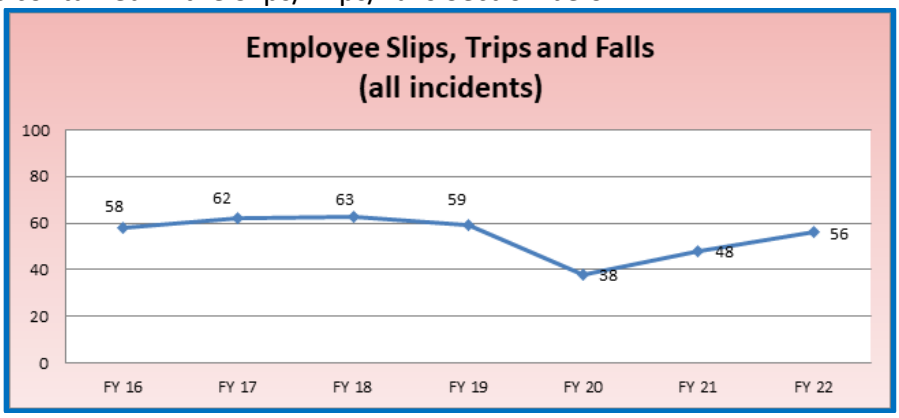


Analysis

- In FY22, we had an **8% increase** in OSHA recordable injuries compared to FY-21 then again we have **maintained our low loss time rate in the last four years**.
- Injury Rates**:** The three largest injury types contributing to the Cal/OSHA recordable injury and illness rate were **Musculoskeletal Disease (MSD)-not related to patient handling at 34%, Patient Handling and Mobility and Employee Falls are tied at 19%. These injuries account for 72% of the total injuries in F/Y 22.**

Improvement Strategies:

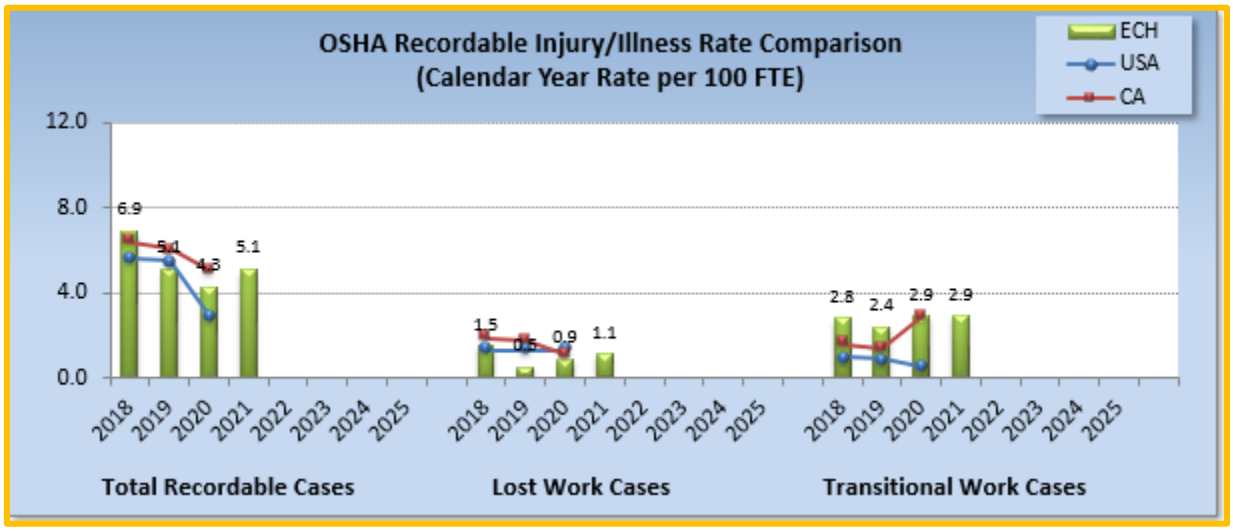
Employees' slips/trips/falls were the most common, and rising. Cause of injury reported in FY21, and the number of falls continued to rise in FY22 (second largest injury type). More information is contained in the Slips/Trips/Falls Section below.



B. OSHA Recordable Injury/Illness Rates as Compared to U.S. & CA Hospitals.

The Department of Labor, Bureau of Labor Statistics (BLS) calculates the recordable injury and illness rates for all hospitals in the USA and California[2].

[2]The BLS data is calculated by calendar year. Data for the last full year is typically not available until fall.



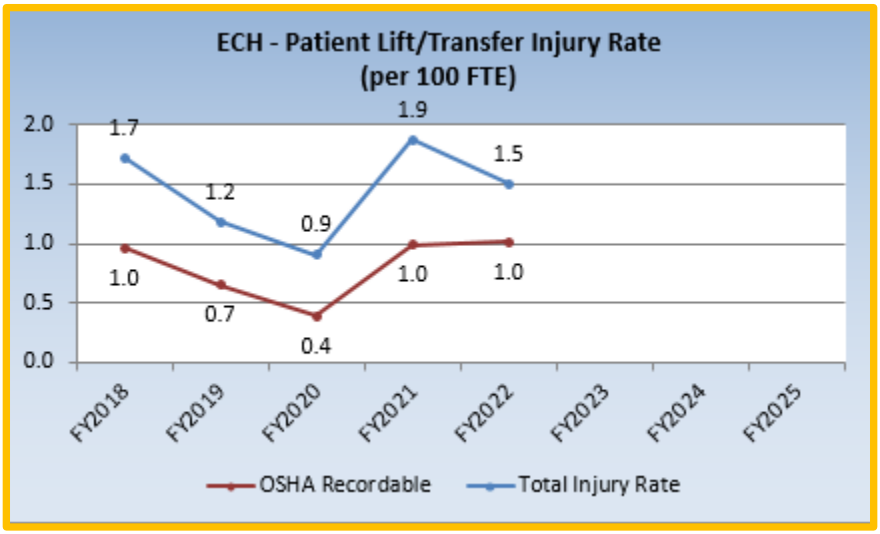
The ECH injury/illness rate in ***calendar year 2021*** was 5.1. The most recent year available from the BLS is 2020. If we compare calendar year 2020 total recordable cases against CA and National rates, El Camino Health is a little above national rate but below the CA rate. The ECH lost work cases rate was 0.9 in 2020, which is below national average and below state average. Our lower rate in lost time cases is due to our robust Transitional Work Assignment(TWA) program. Lost time rate in calendar year 2021 was 1.1, which continues to be very low.
El Camino Health's robust TWA Program shows a commitment to getting people back to work as quickly as possible after an injury or illness, explaining our slight above average transitional work cases (2.9) compared to the national and state averages. Calendar year 2021 transitional work cases rate is 2.9 consistent with 2020.

C. Safe Patient Handling and Mobility (SPHM) Injuries

Analysis

- **Injury Rates**: The rate of OSHA recordable SPHM injuries per 100 FTEs **held steady in FY22 at 1.0 compared to FY21.**
- **Total Injuries**: The total number of SPHM injuries decreased from 49 in FY21 to 37 in FY22 **for a 25% reduction**.

SPHM Injuries: Total Reported vs OSHA-Recordable (Fiscal Years 2018-2022)

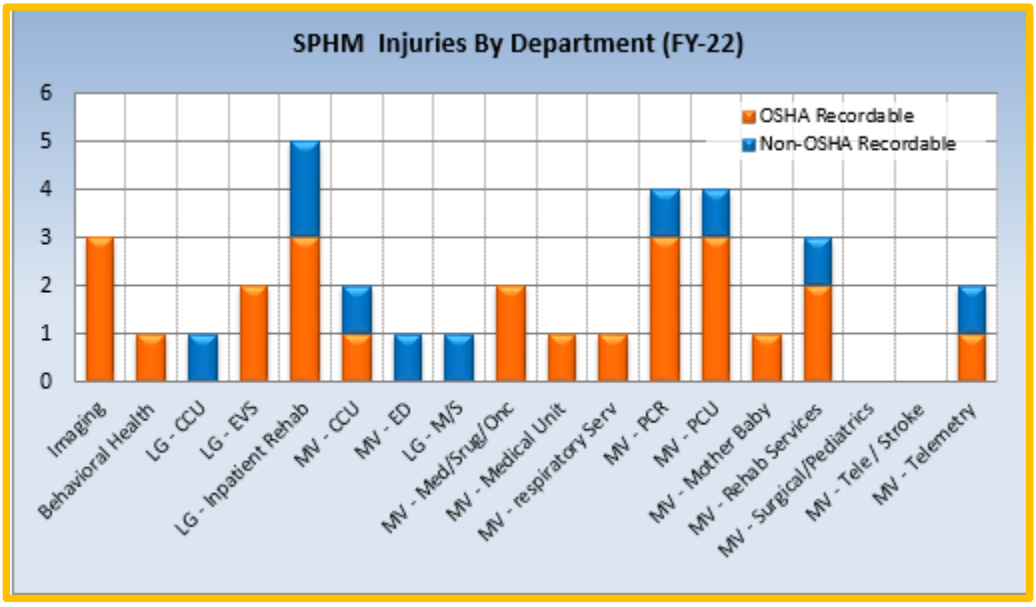


- **Lost/Restricted Days due to SPHM Injuries:** We had 36 days of lost time related to SPHM injuries in FY22. To put this in perspective, **this number accounts for only two of the 28 OSHA recordable cases in FY22. One case had 17 days of loss time and the other had 19 days.**

SPHM Injuries by Type, Fiscal Years 2018 – 2022

Activity	2018	2019	2020	2021	2022
Combined Transfer	5	5	2	3	1
Cumulative Pt Tranfer	4	0	1	2	5
Lateral Transfer	1	5	3	9	4
Patient Fall/Prevention	9	8	8	10	3
Car Extraction	0	0	1	2	1
Pt Holding	3	2	1	5	0
Turning/Pulling	16	5	6	17	11
Vertical Tranfer	3	4	1	2	3

- There was a **70% reduction** of SPHM injuries due preventing/assisting patient falls, In comparison to FY21.
- Turning/Pulling consistently remains our leading SPHM cause of injury although we saw a 35% reduction from the previous year.



Injuries by department

- LG Inpatient Rehab, PCR and PCU Medical units incurred the most injuries, but almost no department was spared.

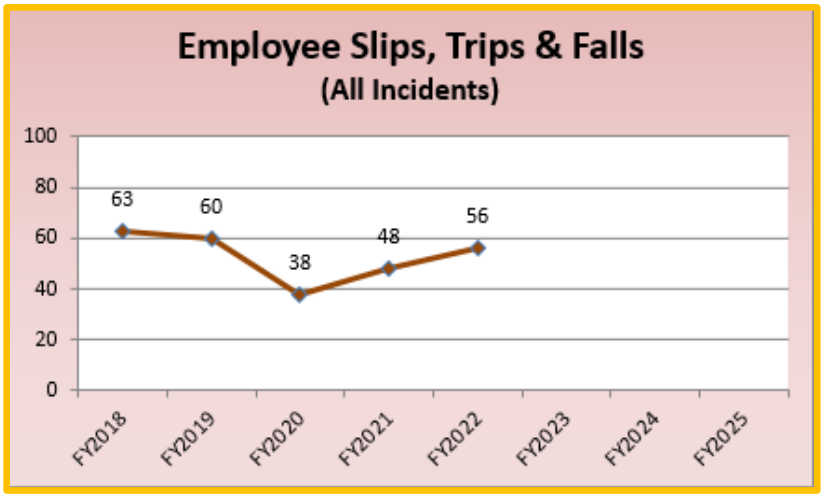
Improvement Strategies:

- Maintenance of a robust SPHM program and education has been challenging in the setting of a pandemic, with competing demands and monthly meetings and in-person trainings postponed. Reliance on meeting remotely through Zoom has improved attendance and involvement.
- Performance of the PMAT (Patient Mobility Assessment Tool) has been mandated and improving communication continues to promote both equipment use and fall prevention.
- The organization continues to be confronted with identifying means to train and empower Safe Patient Handling Unit champions to continue progress in injury reduction during a pandemic demanding social distancing.
- Consideration of an alternative friction-reducing transfer product must be evaluated in light of the increase in injuries due to repositioning and the lack of use of the current device.

D. Slips, Trips, Falls Injuries

Analysis

Injury Incidence: Targeted interventions to reduce Slip, Trip Fall (STF) injuries were initiated in FY17 due to the consistently rising incidence. There was a slight decline in FY19, followed by significant reduction in FY20. We can see an upward trend with a **47% increase in FY22** in comparison with FY19 (our lowest rate in 5 years).



Injury Types:

Contaminants/slippery floor continues to be the most significant cause of STFs.

Bodily reaction, or "I just fell" continues to be the second most common cause, with a higher rate as compared to prior years.

	Contaminant	Cord/Tubing	Object	Ice/Snow	Carpet/Mat irreg	Surface irreg	Bodily rxn	Lack of Space	Steps/Handrail	Chair/Stool	Lighting	Footwear	Curb/Wheelstop	Unknown	Total	Outside	OSHA
FY 17	11	7	10	1	1	1	15	0	7	8	0	1	0	0	62	12	32
FY 18	19	8	9	1	1	7	8	0	4	5	1	0	0	0	63	18	35
FY 19	12	7	10	0	0	6	9	1	8	6	0	0	0	0	59	15	20
FY 20	13	2	8	0	0	2	3	1	4	0	1	2	3	0	38	12	17
FY 21	14	4	7	0	0	2	10	1	3	5	0	2	0	0	48	5	18
FY 22	20	5	4	0	0	3	7	1	3	6	0	5	2	0	56	6	30

Improvement Strategies:

We have had targeted interventions for the last 6 years and there has been little improvement overall.

In FY22, there were 56 STFs and 30 of those were OSHA reportable "with injury." This is almost double from FY21.

Some of our efforts include:

- ✓ targeted communications,
- ✓ met with managers monthly,
- ✓ created tag lines (Put A Lid on It),
- ✓ trialed and introduced products (cord clips),
- ✓ provided cup covers,
- ✓ improved compliance and standardization of safety equipment (shoe covers),
- ✓ redesigned landscaping, posted signage on stairs and in landscaping,
- ✓ painted curbs and hazard areas, and

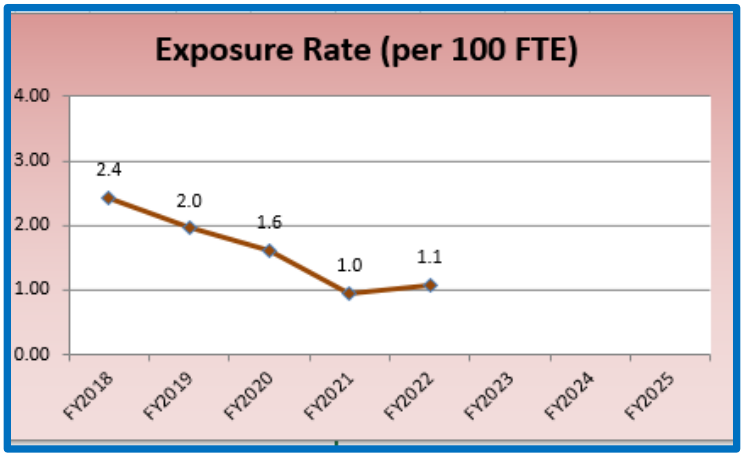
What we have not done is provide significant resource toward the most common cause of falls: contaminants on the floor, which make it slippery. Every year it has been the most significant factor.

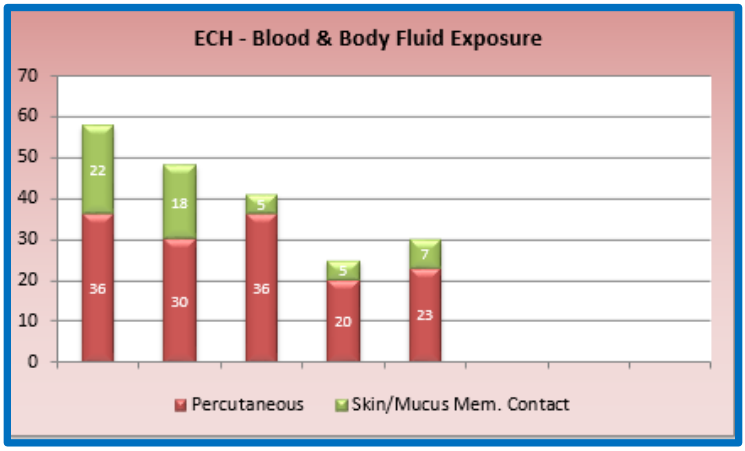
E. Blood-borne Pathogen (BBP) Exposures

The rate of blood-borne pathogen exposures per 100 FTE **increased slightly to 1.1 in FY22 compared to 1.0 in FY21.** The total number of exposures for both campuses increased to 30 exposures in FY22 compared to 25 in FY21. Of these, 23 were percutaneous exposures and seven were body fluid exposures due to splashes.

Analysis:

- In October 2019, a full needle conversion was implemented in both campuses, based on findings by our Sharp Taskforce and to reduce variation among floors and among campuses. This has shown a consistent decrease in needle sticks in comparison to the years' prior the conversion.
- **In FY22 we maintained a 42% reduction in overall needle sticks compared to FY20**
- The implementation of universal masking and eye protection programs due to COVID-19 continues to directly contribute to the **decrease in BBP exposures due to splashes**.





Improvement Strategies:

- Continue Sharps Training as part as Nursing Orientation/General Hospital Orientation.
- Continue to meet 1:1 with injured employees to identify preventable root causes.
- Continue to advocate for universal eye protection beyond the COVID-19 pandemic, as it has significantly reduced our exposures due to splashes.
- EWHS continues to collaborate with Clinical Education to explore ways to increase awareness and possible education among our nursing new graduates.

F. TB Conversions

There were no known occupational exposure conversions at either campus during FY22.

G. Safety Training Indicators

Ensuring staff receive the necessary and required training to safely perform their duties is a critical element of the safety program. A combination of classroom and computer-based training is required for all employees. The Life Safety courses required for all employees and provided as on-line modules on topics including fire, evacuation, hazardous materials, and other safety topics.

H. Safety Inspections

Safety inspections (Environmental Tours) are conducted monthly. Clinical departments are inspected twice per year, once by the Safety Inspection team, and once by the unit. Nonclinical areas are inspected annually by the Safety Inspection team. Problems noted are documented and delegated to the department manager and remain open until corrected.

The top five noted problems in calendar year 2022 involved:

Problem Type	Category
• Are all ceiling tiles in place and in good condition (unbroken, free of dirt, mold, dust, water stains)?	*General Safety*
• Are items stored at least 18-inches below fire sprinkler heads?	*Fire Safety*
• Are all electrical panels accessible – not blocked by carts, boxes, trash cans, or other items?	*Utility Management*
• Are all fire alarm pull stations accessible with three feet clearance?	*Fire Safety*
• Do all fire extinguishers have three foot clearance?	*Fire Safety*

Effectiveness

Key indicators were identified to establish goals for FY22 with opportunities to improve Safety Management within the Environment of Care.

FY 22 Goals:

EOC Area	Indicator	Responsible Dept./Function	Target
Safety	**Reduce employee injuries related to slips/trips/falls**	**EWHS /EH&S**	**Reduce employee injuries related to falls by 15%**

This goal was accomplished. In FY22, **we reduced employee OSHA Recordable lost time injuries related to slips/trips/falls by 63%. In FY22**, we had seven injuries related to slips/trips/falls compared to 19 in FY21.

	SAFETY EVENTS	Performance FY22, Q4	Performance FYTD 22	Baseline FY21 Actual	Target FY22 Target/ Goal
10	**Employee Falls** *per 1000 Adjusted Patient Days (excludes volunteers, visitors, MDs and patients)* *Reporting period: Apr - Jun 2022*	0.16 (9/ 55181)	0.13 (28/217717)	0.25 (total 48 falls)	0.21 (15% reduction from baseline)

Employee Health Services Definitions

1. OSHA Recordable Injuries / Illnesses per 100 FTEs	Number of injuries/illnesses multiplied by 200K divided by the number of Productive Hours* during the reported quarter. [# of OSHA recordable injuries ∗ 200,000 / Productive Hrs.]
2. Lost Work Day NEW cases per 100 FTEs	Total number of new injuries occurring in this fiscal year quarter multiplied by 200K divided by the number of Productive Hours* during the reported quarter.

	[# new cases in qtr. w/ lost work days * 200,000 / Productive Hrs.]
3. Patient Lift / Transfer Injuries per 100 FTEs	Number of OSHA recordable injuries resulting from a specific event involving the lifting and transferring of patients and/or pulling up in bed multiplied by 200K and divided by Productive Hours*. Does not include pushing patients in beds, gurneys, wheelchairs, or other transport devices. [# patient lift injuries * 200,000 / Productive Hrs.]
4. Exposures to Blood and Body Fluids per 100 FTEs	Number of exposures to blood/body fluids during a quarter or year x 200K divided by Productive Hours*. [# BBPs * 200,000 / Productive Hrs.]
5. Productive Hours	Total number of hours worked for the quarter or year by all organizational employees. Includes overtime but does not include education, vacation, PTO, ESL, or other non-productive time. This does not include outside labor.

EC 2.0 - Security Management

Work Group Chair: ***Matt Scannell***

Scope

The Security Management Plan is designed to promote a safe and secure environment and to protect patients, visitors, physicians, volunteers, and staff from harm. Hospital security activities and incidents are managed by the Workplace Violence Committee and are reported to the Central Safety Committee. This data includes, but is not limited to, the following:

- Accidents
- Audits/Inspections
- Assaults
- Burglary
- Code Gray
- Code Green
- Code Pink/Purple
- Disturbance
- Fire Drills
- Missing Property
- MV/LG Community Crime Data Analysis
- Parking Management
- Robbery
- Suspicious Activity
- Thefts
- Trespassing/Loitering
- Vandalism
- Workplace Violence Events Review

Workplace Violence Prevention Plan

The Workplace Violence Prevention Plan is required by Cal-OSHA (Section 3342 of Title 8 of the California Code of Regulations). This plan is specifically for healthcare workers. The WPVP program at El Camino Health is overseen by the Workplace Violence Prevention Committee. There are four required elements to the plan:

1. Written Plan: The plan is reviewed and updated annually.
2. Response: The plan includes a comprehensive violent incident investigation process.
3. Training: The hospital has developed two levels of training.
    - **AVADE** – Computer based training module assigned annually to most staff.
    - **Nonviolent Crisis Intervention (NCI) training** – module and classroom assigned to employees working in departments considered "High Risk" whose assignments may involve confronting or controlling persons exhibiting aggressive or violent behavior. This class is assigned to:
        - Behavioral Health
        - Emergency Department
        - Facilities Engineering
        - Charge Nurses/Clinical Managers
        - Assistant Hospital Managers (Hospital Supervisors)
        - Security
        - Course is also available as an option to all staff.

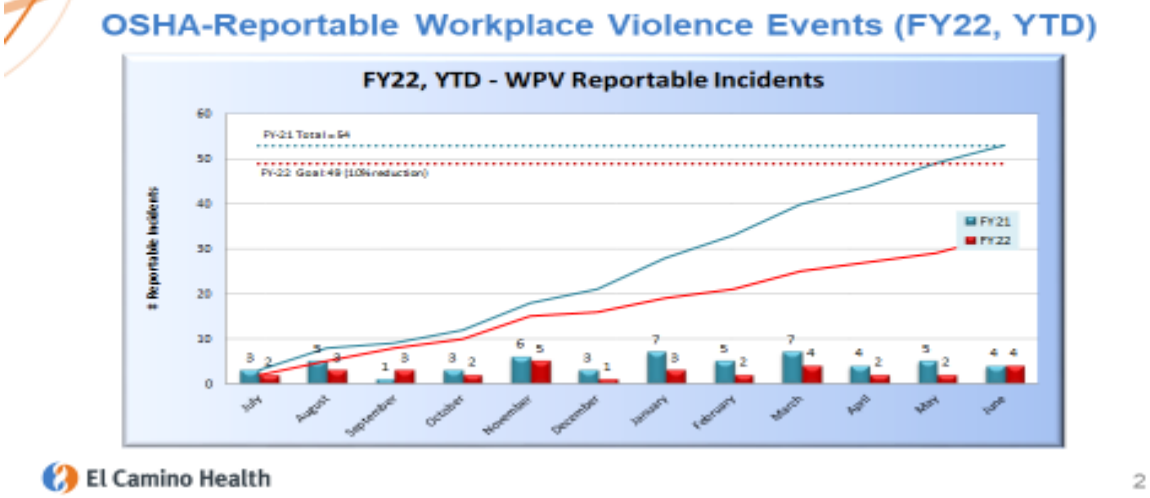
    Note- Due to COVID-19 we suspended in person hands on training and went to on-line only curriculum.
4. Reporting: An ongoing WPV Reporting team ensures reporting is completed as required.
    - OSHA requires reporting of ALL physical assaults of employees regardless of whether the incident resulted in an injury or not.
    - In FY22, 38 incidents were reported to CAL-OSHA. 65% of the incidents resulted in no injury. The remaining events were minor injuries with 75% being bruises or abrasions. No major injuries were reported.

Performance

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the "Trends Report". The following performance criteria monitor Security Management for FY22. The data includes activity from both campuses.

There were a total of 510 reported security incidents for FY22 requiring immediate response. This is a slight decrease from the FY21 of 534.

Review of the major FY22 incidents showed:

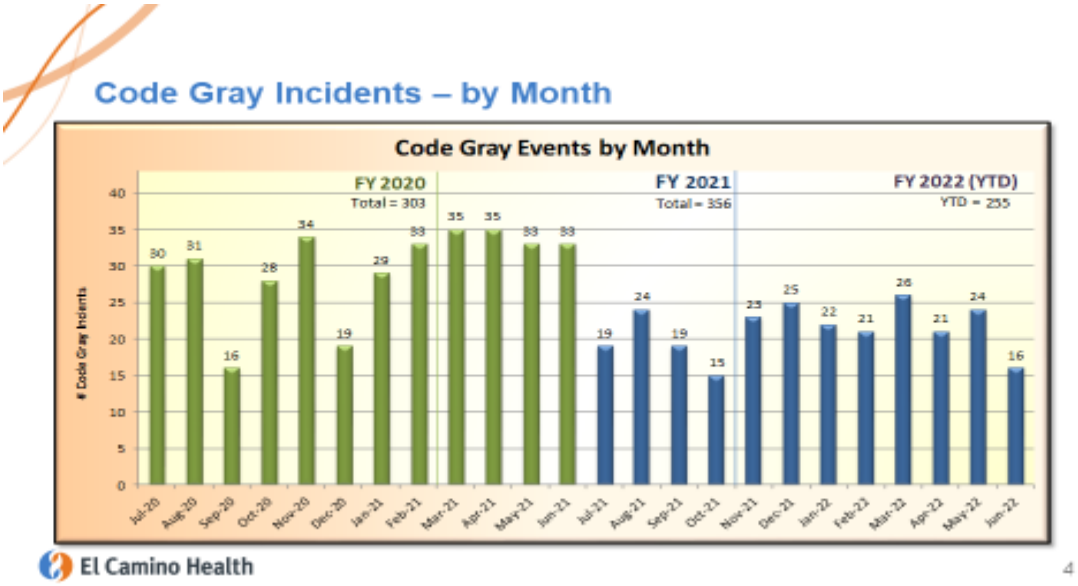


- There were 38 Workplace Violence (WPV) incidents reported to CA-OSHA. This is a 37% decrease from FY21. Contributing factors to this decrease in reportable CAL-OSHA workplace violence incidents can be attributed to the following:
  - More focus on the root causes of workplace violence events in the WPV committee.
  - Better communication and preparedness between clinical departments on patients that have already been combative during their Hospitalization.
  - A renewed focus on strategies to deal with elderly dementia patients that showed an increase in the number of reportable workplace violent reports in FY21.
  - More proactive use of the combative patient flagging tool in Epic.
  - An overall decrease in the number of patients and visitors due to COVID visitor restrictions.
  - Daily communication between the clinical staff and the security staff on patients that have the potential to be combative.

Note - The number of events decreased but the events increased in their combative or violent nature.

A. Code Gray Responses

Code Gray responses decreased in both MV and LG. The total number of incidents in FY22 was 255 compared to 356 in FY21.



Data shows Code Gray incidents and other urgent requests for Security assistance appear to occur with greater frequency in the ED and Medical Units:

- MV Emergency Dept. (ED) – 56%
- MV Medical Unit (2C) – 16%
- MV Telemetry/Stroke (3C)-14%
- MV Progressive Care unit (PCU) – 13%

Responses are tracked through the Code Gray critique and the security shift report form and monitored to help identify possible improvements to the process.

The Hospital utilizes the **Non-violent Crisis Intervention® (NCI)** training program for all staff who deals with angry or agitated persons. This is part of the Workplace Violence Prevention program and is required for staff in designated high-risk areas. Staff in other departments is encouraged to take this training as an optional course.

B. Bulletins, Alerts & Presentations

Security Services issued 10 personal safety alerts, security prevention announcements, law enforcement advisories and awareness presentations and other hosted discussions.

C. Patient Belongings

Security Officers performed 6,235 chain-of-custody transactions involving patient's belongings.

D. Patient Escorts, Watches, Standbys & Restraints

Security Officers performed 2,434 patient watches, standbys and restraints. This was an increase over FY21 (2340). Hospital Supervisors or Nurse Managers notify Security of these events, which can last several hours. They primarily occur in the Emergency Department, Mental Health and Addiction Services (MHAS) and on the Medical Units. Patient watches are also handled by ED Technicians, Patient Safety Attendants (PSAs), and others which may not be included in these numbers.

E. Fire Drills / Fire Watches

Security Officers conducted 112 fire drills and are 100% up-to-date. A total of 4 fire watches were performed in FY22.

F. General Assistance

Security Officers performed 44,165 service requests including but not limited to main lobby greeter assistance, directional requests, door locks/unlocks, escorts, issuance of one-day passes.

G. ID Badges

Security Services issued 1,932 Photo ID Badges with access and barcoding technology to staff, physicians, auxiliary, contractors, and students. 1,331 temp badges were issued.

H. Investigations & Audits

Security Services performed 98 investigations and audits including, but not limited to fact-finding, interviews, case follow-up documentation, intelligence gathering, and physical security assessments or systems review.

I. Lost and Found

Security Officers performed 434 chain-of-custody transactions involving Lost and Found items for patients, visitors and staff.

J. Inspections

Security Services performed a total of 84,232 inspections (weekly and monthly items) including but not limited to fire extinguishers, eyewash stations, panic buttons, exterior campus lighting, emergency phones and delayed egress door checks.

K. Loitering

Security Officers responded to 332 incidents involving problematic individuals who required extra time and assistance leaving hospital property. Note: These incidents may be a subset of data from other sections in this report.

L. Parking Compliance & Services

In addition to daily parking control and 'space availability' counts, Security Officers performed 113 vehicle-related services including jump-starts, door unlocks and tows. 296 citations and warnings were issued to vehicles on Mountain View and Los Gatos campus.

M. Police Activity

Law enforcement agencies were on-site 168 times in response to requests for assistance, urgent calls and for investigative activities. Note: actual number maybe higher, as Security Services may not be aware of all police activity on-campus.

N. Statistics –Police Department Crime Data

Estimated MVPD Annual Report

Square Miles:	12	11.25
Population:	83,377 (County of Santa Clara 1,945,940)	30,516
Personnel:	148	59 (39 sworn & 20 non-sworn)
Total Calls for Service	6,860	35,524
Statistics ***UCR data includes attempts and actual crimes***		
Part I UCR:	2274 (2103 Property vs. 171 Violent)	488 (477 Property vs. 11 Violent)
Previous Year	2164 (1976 Property vs. 188 Violent)	598 (583 Property vs. 15 Violent)
Part II UCR:	2497	Not Collected
Previous Year	2800	Not Collected
Arrests-Misdemeanor:	1235 (1177 Adult vs. 58 Juvenile)	Not Collected
Previous Year	1553 (1465 Adult vs. 88 Juvenile)	Not Collected
Arrests-Felony:	386 (347 Adult vs. 39 Juvenile)	Not Collected
Previous Year	375 (353 Adult vs. 22 Juvenile)	Not Collected
Traffic Collisions:	467	281
Previous Year	550	Not Collected
Moving Violations:	Not Collected	Not Collected
Previous Year	1827	Not Collected
Non-Moving Violations:	Not Collected	Not Collected
Previous Year	2199	Not Collected
Indexes ***Per 1,000 current year population***		
Violent:[3]	2.11	0.35
Previous Year	2.33	0.48
Property:[4]	26.29	15.53
Previous Year	24.46	18.98

Effectiveness

Key performance indicators were identified in the FY22 to improve Security Management within the Environment of Care.

[3] Violent Crime Index includes Criminal Homicide, Forcible Rape, Aggravated Assault, and Robbery
[4] Property Crime Index includes Burglary, Larceny, Motor Vehicle Theft, and Arson

FY22 Goals

1) 90% non-medical emergency security response time less than 3 minutes.

a) This goal was met.

2) 15% reduction in number of reportable workplace violence incidents- In FY22 there was a 37% decrease in the number of Workplace Violence reports submitted to CAL-OSHA.

a) This goal was met.

3) Reduce the number of reported thefts on both campuses by 10% over FY21 totals- (4) In FY22 there were total of 6 reported thefts (4 in MV and 2 in LG)

a) **This goal was not met.**

EC 3.0 - Hazardous Materials & Waste Management

Work Group Chair: ***Lorna Koep***

Scope

The Hazardous Materials & Waste Management work group is comprised of a multi-disciplinary group from within El Camino Health. The work group chair serves as the central contact point for the reporting and documentation for the work group and provides regularly scheduled reports to the Central Safety Committee.

Performance

A. Hazardous Material Incidents

The Hazardous Materials and Waste Management Work Group maintains an electronic Hazardous Materials Spill Log, which documents reporting and clean up procedures used.

- **Recordable Hazardous Material Incidents**[5]**:**

1) Buffered 10% Formalin- Storage box in CT Control Area – Lid Seal malfunction/not stored in the upright position, contained in secondary container. Cleanup was handled safely. Reviewed procedures for Formalin storage/handling with staff.
2) Valporic Acid Spill- 3C Telemetry/Stroke Room 3316 – While administering Meds, IV hose malfunction -during hose disconnection- material spilled from hole in the IV tubing. Cleanup was handled safely. Reviewed with staff assessment of equipment prior administration of meds and to disconnection of IV.
3) Cisplatin diluted with urine -approximately about 30-50mls. – MV Cancer/Infusion Center patient restroom -patient was urinating and missed toilet. Cleanup was handled safely. Review future patient education on precautions.
4) Unidentifiable liquid leaking from the Yellow chemo bin - LG MS soiled utility room – unknown what caused the spill. Cleanup was handled safely.
5) Chemotherapy Spill 100ml Fluorouracil - 4A Surgical / Pediatrics Room 4133 bathroom and bedside - Patient pulled the top part of the tube where the safety clip is locked in. Tubing had a small tear on the top safety clip. Cleanup was handled safely. Reinforced patient education on moving IV pole in regards to hand placement to avoid further tugging of IV tubing.

- **Reportable Hazardous Material Incidents** – No reportable spills.

[5] Reportable and recordable hazardous material incidents are defined by state and federal regulations and are determined based on the quantity and hazard of the spill.

B. Waste Water Discharge Violations:

- **No Waste Water Discharge Violations**

C. Monitoring and Inspections

- **Hazardous Waste Inspections** – No Inspections for FY22
- **Santa Clara County Annual Medical Waste Inspections** – No Inspections for FY22. April 6, 2022 County Medical Waste inspector called EVS Director to notify that onsite inspections would be resuming for the county. Inspector asked for the current Visitor Guidelines to be sent. Visitor Guidelines March 25, 2022 were sent same day. No inspection date was scheduled and no inspections occurred.
    - Continued monitoring and education to ensure waste segregation compliance:
        - Annual Waste Management education for staff
        - Daily rounds by EVS supervisors
        - Monthly Safety Rounds that include observation of waste segregation practices
        - Quarterly Surveys of medical waste/sharps by Stericycle Compliance Coordinator with targeted education on nursing units addressed toward survey findings.

D. Radiation Safety Committee

The Radiation Safety Committee reports to Central Safety as part of the Hazardous Materials Management work group. Minutes of the Committee meetings are reviewed quarterly at the Central Safety Committee.

Effectiveness

Staff training on hazardous materials is completed through computer-based training modules and is reported by the Safety Management Work Group. In addition, representatives from all areas represented in the Hazardous Materials Work Group completed a 40-hour HAZWOPER[6] training course.

Key indicators were targeted to establish goals for FY22. The following goals presented opportunities to improve hazardous materials & waste management.

FY22 Goals:

4. Review and revise the Hazardous Waste Stream Identification Policy and Hazardous Waste List attachment with an emphasis on Stakeholder Department's Hazardous Waste identification and handling through assessment, education providing accurate Hazardous Waste stream list.

[6] HAZWOPER: Hazardous Waste Operations and Emergency Response

a. **Measurement of success**:

i. 100% Completion review of Stericycle El Camino Health's 2021 Waste Stream Report followed by Gap assessment by Stake holder departments.

ii. 100% Completion of education to appropriate staff of Stakeholder department, based on gaps identified.

iii. 100% Completion of report of Hazardous Waste list per department

iv. 100 % Completion of updated attachment of the Hazardous Waste stream list to the Hazardous Waste Stream Identification Policy**.**

b. This goal was partially accomplished-75% of goal accomplished

i. Updated list (# iv., above) not complete, waiting for outside consultant to advise on Hazard Class and method of disposal for each waste before updating policy online

5. Review and re-educate CsRX usage per regulatory standards, collections and communications for full container swap out for exchange. Joint Commission Mock Survey identified a gap of nursing continuing to pour controlled substances into the CsRX container after container had reached capacity resulting in unsafe conditions.

a. **Measurement of Success**:

i. 100 % completion of flyer created by Education Department

ii. 100 % completion of Electronic Distribution of Educational Flyer to Clinical Staff.

iii. 100% completion of Posting Flyer near all CsRX containers

iv. Successful Joint Commission Survey with full compliance on CsRx Containers and usage.

b. **This goal was accomplished – 100%**.

EC 4.0 - Fire Safety Management

Work Group Chair: *John Folk*

Scope

The Fire Safety Management Plan is designed to assure appropriate, effective response to a fire emergency situation that could affect the safety of patients, staff, and visitors, or the environment of El Camino Hospital. The program is also designed to assure compliance with applicable codes, standards and regulations.

Performance

Performance indicators for the Fire Safety Management program are reported monthly and/or quarterly to the Central Safety Committee and are reflected in the Trends Report. The following performance criteria are reflective of the indicators established in monitoring Fire Safety Management for FY22.

A. Fire Incidents

There was one reported fire incident in FY22. This occurred in the MRI suite in Mountain View. A workstation on wheels (WOW) had an electrical malfunction, which caused the monitor to catch fire. Staff responded appropriately and staff with a fire extinguisher extinguished the small electrical fire.

B. Fire Alarm Events

A fire alarm event is the activation of the fire alarm system determined not to be due to an actual fire incident. All cases are evaluated for potential opportunities for improvement.

The total number of events in FY22 (45) was slightly higher than FY21 (44). There were 43 events in Mountain View and 2 in Los Gatos. This was accomplished despite heavy construction activity at both hospitals during FY22. Fire Drills Completed / Scheduled

All required fire drills (94) were completed in FY22. For all drills, there were 24 required actions by staff. All issues were fully corrected either on the spot or with further education by the dept. Manager.

Note: There were fewer fire drills in FY22 due to moving all operations out of Old Main hospital.

Effectiveness

Based on opportunities for improvement identified in FY21 annual EOC evaluation the FY22 Performance Improvement Indicators were as follows:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Fire Prevention	Staff knowledge of the nearest fire extinguisher and fire pull station.	Engineering, Security and Department Managers	>90%	**100%**
Fire Prevention	Staff knowledge of the emergency telephone number 55	Engineering, Security and Department Managers	>90%	**99%**
Fire Prevention	Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	>90%	**97%**

Note: We will choose all new indicators for FY23 due to staff performance in FY22.

EC 5.0 - Medical Equipment Management

Work Group Chair: *Jeff Hayes*

Scope

The scope of the Medical Equipment Management Plan encompasses all medical equipment used in the diagnoses, monitoring and treatment of patients. The Medical Equipment Management Work Group supports the delivery of quality patient care in the safest possible manner through active management of medical equipment.

Clinical Engineering supports all medical equipment. This process is reported to, and overseen by, the Central Safety Committee.

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually. Performance indicators are monitored monthly or quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Medical Equipment Management for the FY22.

A. Reports to the FDA

There were 2 reports through the Medwatch[7] system in FY22. There were no patient deaths associated with any of the reports.

B. Preventative Maintenance (PM) Completion Rate Percentage

The PM completion rate did not meet compliance for the target of 95% completion in all areas.

- The completion rate for Clinical Engineering achieved 87% for FY22. A 13% improvement from FY21. All devices were 100% managed through a communication process to locate all devices.
- All high risk, life safety equipment was maintained at 98% completion rates. A 10% improvement from FY20. All devices were 100% managed through a communication process to locate all devices.

C. Product Recalls Percentage Closed / Received

For FY22, there were 93 recorded equipment recalls; 9 still being addressed.

[7] The FDA Medwatch System is used to report all incidents impacting patients and not only serious events resulting in patient deaths.

D. Effectiveness

FY22 Performance Indicators

1. Improve the confidence level of the active assets in the inventory to greater than 90%.

   - **Measurement of Success**: Currently we are at an 84% confidence level of assets active in the database. This will be accomplished by tracking scheduled work orders on an asset by various sub status codes to assure the asset is a valid active asset and should remain in the inventory.

     - **This goal was accomplished**. We reach and exceeded our goal. Through a process of identifying, documenting and communicating with department for assistance in locating assets in the database we were able to able to attain a 95% confidence level in our inventory.

2. Develop two network indicators that will alert potential monitoring network failures.

   - **Measurement of Success**: These indicators will provide solutions to preemptively resolve potential issues within the networked monitoring system. Previously, we only had Philips HL7 as an alert but in collaboration with Philips interface engineer and our hospital interface engineering, there were rules put in place to notify us with 15min of inactivity.

     - **This goal was accomplished**. We setup an alerts for our interfaces where various IT team members and Clinical Engineering get notified via email for the following interfaces to preemptively resolve any networking issues affecting patient care;

       - Philips ADT Philips HL7
       - Philips VS30 Communication
       - Philips Intellispace HL7
       - Philips Intellispace ADT

EC 6.0 - Utilities Management

Work Group Chair: *John Folk*

Scope

The scope of the Utilities Management Plan encompasses all utilities used to support the mission and objectives of El Camino Hospital. The Utilities Management Work Group is designed to support the delivery of quality patient care in the safest possible manner through active management of all utilities systems. This process is reported to and overseen by the Central Safety Committee.

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually as a function of the Central Safety Committee. Performance indicators are monitored quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Utility Management for FY22.

A. Utility Reportable Incidents

There were three reportable incidents in FY22. All were electrical outages or voltage fluctuations.

- In October, Los Gatos had a momentary loss of electrical utility (PG&E) campus wide.
  - The October event activated the emergency generators.
- In November and January, Mountain View had a loss of electrical to the campus due to a PG&E mechanical malfunction.

B. PM Completion Rate % completed/ scheduled

The Utility Systems PM completion rate was **98%,** meeting the goal of 95%. Critical systems were maintained as required for the facility operations.

C. Generator Test percentage completed/scheduled

The percentage of the generator tests completed was 100% with compliance in loads, times, and transfer switch testing frequencies.

Effectiveness

Key indicators were targeted to establish goals for FY22. The following goals presented opportunities to improve Utility Management within the Environment of Care:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Utility Management	Staff can describe the proper way to store oxygen cylinders as well as the amount per smoke compartment	Engineering, Security and Department Managers	>90%	100%
Utility Management	Staff can describe who has the authorization to turn off medical gas controls.	Engineering, Security and Department Managers	>90%	100%

Note: With 100% compiance new indnctrs will be chosen for FY23

EM – Emergency Management

Committee Chair: *Daniel Peck*

Scope

El Camino Hospital's Emergency Operations Plan addresses all non-fire related internal and external emergencies impacting the El Camino Health environment of care. The Emergency Management Committee ensures an effective response to these events. The hospital actively participates with state and local emergency management entities to coordinate community planning efforts and response. Emergency Management is a separate chapter under The Joint Commission; however, the annual reporting is being combined with the Environment of Care report.

Performance

Performance indicators for the Emergency Management program are reported through the monthly meetings. Significant events are presented quarterly to the Central Safety Committee. The following Emergency Management indicators were reported in FY22.

B. Activation of Hospital Incident Command System (HICS)

There were zero recorded events and/or emergencies during FY22 requiring activation of HICS and opening of the Hospital Command Center (HCC).

C. Exercises / Drills

The Joint Commission requires each facility to activate HICS and open the HCC for a surge of simulated or actual patients at least twice per year. In FY22, this was met through separate planned exercises at both campuses (see below) and the continuing COVID-19 pandemic response. The exercises are summarized below. After Action Reports were created for each exercise that included action items to be implemented to improve future responses.

Note, during most years, the hospitals participate in a statewide medical and health exercise in November. Due to COVID-19 pandemic, the statewide event was cancelled.

a. **Great California Shakeout Exercise (10/21/21)** – Both MV and LG participated in the great California shake out drill with Santa Clara County. A functional exercise was conducted at each campus to test procedures and plans should the hospitals be directly or indirectly affected by an earthquake.

    a. **Santa Clara Valley Emergency Preparedness Medical Response and Surge Exercise. (05/31/22)** – Both MV and LG participated in a Santa Clara countywide surge planning drill. A functional exercise was conducted at each campus to test surge planning procedures and plans should the hospitals be impacted by a mass shooting event off campus.

b. Additional Exercises were conducted to assess and test our preparedness to other emergency events

- **Code Pink Drills – Mountain View & Los Gatos** - Exercises were conducted at both campuses to test staff's ability to respond to an infant security band alert.

D. Emergency Management Training

- **New hire orientation** (100% for all employees)
- **Safety coordinator meetings** (72% attendance overall for the quarterly meetings). Safety Coordinator meetings are presented in-person and on Zoom. Recordings of the meetings are also available for staff unable to attend live.
- **CHA Disaster Preparedness Conference –** the CHA hosts an in-depth conference related to disaster response and preparedness each year in September. The hospital has always sent a contingent to this conference. This year, the conference was streamed live so additional staff were able to attend remotely.

E. Community Involvement

The hospital continues to be an active participant in the Santa Clara County Hospital Emergency Preparedness Partnership (SCCHEPP) and the Santa Clara County Emergency Preparedness Healthcare Coalition (EPHC). The SCCHEPP group meets monthly with representatives of all Santa Clara County hospitals and the county EMS. The emphasis is creating a collaborative county-wide emergency response and disaster plan. The group also organizes and facilitates county-wide disaster exercises in which the hospital actively participates.

The EPHC expands many of the same elements of the SCCHEPP to all healthcare facilities in the county including clinics, skilled-nursing facilities and dialysis clinics. This group meets quarterly and shares information and provides training to help all healthcare facilities prepare for emergencies. Hazard Vulnerability Assessment (HVA)

The HVA is an assessment of each facilities risk for various emergency situations. The HVA is reviewed and revised annually. Separate HVA's are completed for the Los Gatos and Mountain View campuses to account for physical differences in the locations and facilities. Efforts are then focused on attempting to minimize the highest risks during the fiscal year.

- There were several changes to the HVAs at both campuses in FY22 based upon local and real-world events. The top five hazards by campus are:

Mountain View	Los Gatos
(1) Earthquake	(1) Earthquake
(2) Pandemic	(2) Pandemic
(3) Infectious Disease Outbreak	(3) Infectious Disease Outbreak
(4) Patient Surge	(4) Patient Surge
(5) Cyberattack	(5) Power Outage

F. Effectiveness

Key indicators were targeted to establish goals for FY22. The following goals presented opportunities to improve emergency management.

FY22 Goals

4. Expand the use of mass notification system (Everbridge) to all employees (continued from FY21)
   - **Measurement of Success**
     - Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.
     - Evaluate and set up logical groups and rules for notifications.
     - Train key staff to be able to use/send alerts
   - **This *goal was accomplished.***
     - All employees with Workday accounts are now included in a nightly update of the Everbridge database.
     - Groups are set up to allow custom notifications by campus, department, job classification, and geographic location.
     - Call Center staff are being trained on the use of Everbridge to allow for rapid notifications as needed.
5. Incorporate and expand emergency exercises in the new facilities at El Camino Health – Los Gatos Cancer Center, Taube Pavilion, Sobrato Pavilion, and Willow Outpatient Surgery.
   - ***This goal was accomplished.*** All exercises have been expanded to include all pavilions in planning and participation.
6. Revise Hospital Surge Plan.
   - ***This goal was accomplished.*** The Hospital COVID-19 Pandemic Plan was used as a reference to revise the Hospital Surge Plan. The plan was reviewed and approved by the Emergency Management Committee.

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: November 7, 2022
Subject: FY23 First 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 1 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, 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 tracked on the Board Quality Dashboard (STEEEP), which is published once per quarter. The metrics on the STEEEP dashboard are primarily acute care measures. The ECHMN Performance Dashboard for FY23 Quarter 1 is reviewed separately, (during this same committee meeting).

4. Assessment: The first 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. First quarter performance is favorable; (lower is better) HAC Index of 0.77 compared to a FY23 target of 0.986.

      i. Hospital Acquired Pressure Injury (HAPI) Stage 3, Stage 4 and Unstageable. A pressure injury wound is numerically classified as Stage 1 or 2 or 3 or 4, based on the deepest tissue type exposed. The higher the number, the deeper the wound. Six of our patients had a) Stage 3, Stage 4 or Unstageable HAPI in FY2021 and eight had a HAPI in FY2022. To achieve a 7.5% reduction for FY23 our target is to have less than 8 HAPI occurrences in FY23. This translates to a goal of having less than 2 HAPI per quarter. To be on track for HAPI performance we would want to see 1 or no stage 3 or 4 pressure injuries in the first quarter of FY23. We had 2 patients have Stage 3, Stage 4 and Unstageable HAPI in Q1 of FY23. Improvement efforts include a focus on device related pressure injuries. Both HAPIs in Q1 were

related to medical devices; a nasal cannula for oxygen delivery, an abdominal feeding tube insertion site. According to the literature, medical-device related pressure injuries now account for more than 30% of all hospital-acquired pressure injuries. (The Joint Commission, July 2018) Respiratory therapy staff have collaborated with our wound care team to collaborate and implement best practices to protect patient's skin who require prolonged use of supplemental breathing support with a medical device. As of October 22, 2022, respiratory therapy team is performing 'skin' rounds to ensure we are proactively protecting skin in contact with respiratory medical devices.

B. Timely Care

i. ED Imaging Turnaround Time. This metric measures the amount of time it takes from imaging study is ordered to when the images have been taken by a radiology tech, the images interpreted and reported by the radiologist. This is a new metric on the STEEEP dashboard for FY23. The rationale for escalating this performance measure to the STEEEP dashboard is because of the trend of prolonged radiology reading times affecting the timeliness of patient care and ED throughput. In FY21 13% of studies were outliers, taking >45 minutes for the radiologist to interpret and dictate the report after the exam was completed by the tech. In FY22, 20% of ED studies were outliers. Current performance (78%) is not meeting target (84%) of studies completed within this period. Factors contributing to the pro-longed reading time are the increase volume and complexity of imaging studies ordered in the ED. Radiologist interpretation time is a focus of improvement. Challenges include off-hours results completion delays and StatRad staffing shortages. Dr. Bhimani is working closely with Radiology teams to address these gaps, identify, and support implementation of improvements.

C. Effective

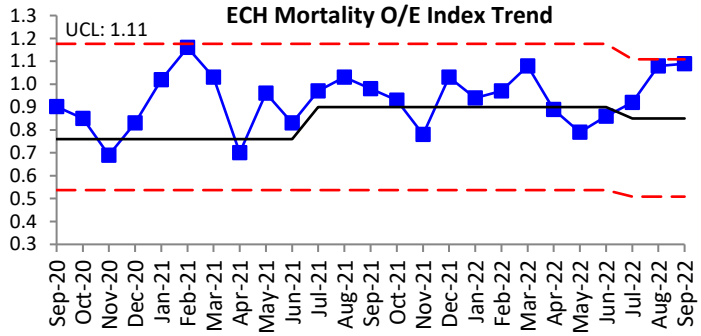
i. Risk Adjusted Readmission Index. Current Readmission Index for Q1 of FY23 is 1.02, unfavorable to the target of 1.00. Management continues to focus on this opportunity to ensure our patients after discharge from the hospital are able to remain home, in long-term care or SNF after discharge, as appropriate for their condition. We are encouraged to see a favorable trend downwards in our risk adjusted readmission rate.

Observed/Expected Readmission Index by Quarter								
Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22	Q1 FY33
0.92	0.97	0.95	0.94	1.05	0.96	1.12	1.06	1.02

ii. Risk Adjusted Mortality Index. The risk adjusted mortality index for Q1 (1.03) is unfavorable to the target of 0.85. For the month of September, 80% of patient deaths were due to Sepsis, Cancer, Cardiac, Stroke and Renal Failure. Having a mortality index >1.0 is not typical for our performance, yet,

remains within the upper and lower control limits for this measure suggesting this is 'acceptable' noise. Each patient mortality included in the measure is being reviewed closely to detect any trends. None has been identified.

As a review, control limits are the horizontal lines on the below statistical process control chart at a distance of ± 3 standard deviations of the plotted statistic's mean, used to judge the stability of a process.



iii. Sepsis Mortality Index. FYTD Sepsis Mortality Index for Q1 (1.02) exceeded the FY23 target of 0.98. An isolated uptick of sepsis deaths in the month of August has been studied and no actionable trends identified. Similar to the control chart displayed above for Mortality Index, the August Sepsis Mortality Index of 1.3 was within the bounds of the upper control limit of 1.48. The Sepsis Mortality Index in September returned to below zero (0.89).

iv. NTSV C-section Rate for Primigravid Woman with a singleton pregnancy. The data for Q1 of FY23 will be finalized in one week. This is a unique core measure in that the results are reported both in Leap Frog for letter Grades and by CMS for star ratings. Leapfrog relies on CMQCC chart abstraction data. CMS relies on IBM for chart abstraction. I identified that the CMQCC and IBM core measure results for the same measure were very different. We have implemented a workflow to ensure the results are consistent. This requires manual review of charts by a physician to verify outliers and ensure numerator and denominator are accurate for both IBM and CMQCC.

D. Efficient

i. Patient throughput Admit Order to ED Departure Median Time. The ED throughput measure tracked on the STEEEP dashboard for FY23 is the "Arrival to Direct Discharge Median time". This is the throughput measure used by CMS to calculate our Star Rating. In spite of a 29% increase in ED volumes FY22 to FY21, the Median Time from arrival to direct discharge decreased favorably from 189 minutes in FY21 to 162 minutes in FY22. Current FY23 Q1 performance is 177 minutes, unfavorable to goal of 162 minutes. Children with respiratory infections (RSV) is contributing to the longer times. As a countermeasure to this increase in pediatric volume we now have respiratory therapists on site in the ED to expedite our care of these sick pediatric patients.

E. Patient Centered

i. IP Units –HCAHPS Likelihood to commend. Inpatient units did not meet target. FY23 Q1 performance is 79.9 < target of 81. This was due to decrease in our scores in Los Gatos Med Surg and Mountain View 3B and 4B. In Los Gatos, those patients that were admitted through the ED scored

us lower. In 3B and 4B, our responsiveness scores were lower. We continue to focus on Nurse Communication and the power of three, which includes Nurse Leader rounding, bedside report and Purposeful Hourly rounding. Rounding in Los Gatos has been challenging due to continued staffing issues but plans are in place to help with that.

ii. ED Likelihood to Recommend Top Box Rating. We did not meet our target for Q1 of FY23. FYQ1 performance of 70.3 < target of 75.0. We continue to have record high census and acuity and we continue to focus on patient flow, improving throughput and wait times. For those patients waiting greater than four (4) hours, are scores decline substantially. We are working on a plan to discharge lower acuity patients quicker.

iii. MCH – HCAHPS Likelihood to Recommend. FY23 performance is lower than goal of 81.5. ECH MCH continues to struggle with visitor and family issues and construction in MCH. We recently changed our visitor policy to allow families into our kitchen areas and cafeteria and have increased our rounding for families impacted by the construction noise. 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 Q1. FY23 Q1 performance of 82.6 < target of 83.4. Every metric in the ECHMN frictionless dashboard improved in September. Primary Care continues to struggle with access; however, we have identified improvements in our scheduling system to help. Specialty clinics improved in all areas.

List of Attachments Attachment 1—Board Quality Dashboard (STEEEP) FY23 Quarter 1.

FY23 Quarterly Board Quality Dashboard (STEEEP)

Quality Domain	Metric	Baseline	Target	Performance				
		FY 22	FY 23	FY23, Q1	FY23, Q2	FY23, Q3	FY23, Q4	FYTD23 Total
Safe Care	HAC Index	1.066	0.986	0.77				**0.77**
	HAC Component: Clostridium Difficile Infection (C.diff)	9.25	8.56	7.00				**7.00**
	HAC Component: Surgical Site Infections (SSI)	4.5	4.16	3.00				**3.00**
	HAC Component: nvHAP	28.75	26.59	26.00				**26.00**
	HAC Component: IP Units area Patient Falls Reported to NDNQI	38.25	35.38	25.00				**25.00**
	HAC Component: HAPI Stage 3, Stage 4 and Unstageable	2.00	1.85	2.00				**2.00**
Timely	Stroke: TTITT (time to intravenous thrombolytic therapy) <= 30 min	28.6% (8/28)	50%	50% (4/8)				**50% (4/8)**
	Stroke: Door-to-Groin <= 90 minutes	50% (9/18)	50%	100% (2/2)				**100% (2/2)**
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)	79.01%	84%	78.43%				**78.43%**
Effective	Risk Adjusted Readmissions Index	1.05	1.00	1.02				**1.02**
	Risk Adjusted Mortality Index	0.94	0.85	1.03				**1.03**
	Risk Adjusted Sepsis Mortality Index	1.02	0.98	1.02				**1.02**
	PC-02 NTSV C-Section	23.50%	23.5%	---				---
Efficient	Patient Throughput- Median Time from ED Arrival to ED Deaprture for *discharged ED patients*	162	162	177				177
Equitable	% Patients - Ethnicity documented	97.90%	----	97.59%				**97.59%**
	% Patients - Race documented	98.29%	----	97.75%				**97.75%**
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	80.8	81	79.9				**79.9**
	ED - Likelihood to Recommend (PG)	74.5	75	70.3				**70.3**
	MCH - HCAHPS Likelihood to Recommend	81.3	81.5	72.3				**72.3**
	ECHMN (El Camino Health Medical Network)	83.2	83.4	81.0				**81.0**

Updated: 111/1/22

Legend

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

Green: At or exceeding target

Yellow: Missed target by 5% or less

Red: Missed target by > 5%

White: No target

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Shahab Dadjou, Interim President ECHMN and Ute Burness, RN, VP of Quality, ECHMN
Date: November 7,2022
Subject: ECHMN Quarterly Quality Report

Purpose: Provide the Board Quality Committee with a quarterly update on the status of ECHMN 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 the 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 and Dependable and Convenient care
B. Likelihood to Recommend (LTR)
C. MIPS (Merit Based Incentive Payment System)

ECHMN has established true north pillars, one of which is quality and service. For Fiscal Year 2023, ECHMN changed to a new way of reporting quality. The new methodology measures the performance of PCP attributed patients on six 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. We have also added dependable and convenient, which include third next available appointment (a measurement of access), timely response to messages and “My chart” activation.

ECHMN is now using Press Ganey as the survey tool to measure patient experience for PCP’s, Specialist and Urgent care. ECHMN transitioned to Press Ganey so that we have a consistent approach and methodology within the entire health system. Press Ganey has the largest market share, so we can compare ourselves against the largest number of organizations in the national, California and the Bay area.

ECHMN Quarterly Quality Report
November 7, 2022

List of Attachments:

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

Suggested Committee Discussion Questions:

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

El Camino Health
Medical Network

El Camino Health Quality Committee Meeting

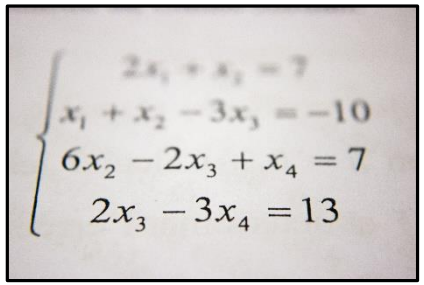
Ute Burness, RN, VP Quality, ECHMN

November 7, 2022

What is ‘new’ for Fiscal Year 2023

Past

Present and beyond



Composite of a point system of 8 clinical measures

ECHMN is focusing on PCP measures, because they are important measures of health and consistent with the priorities of our health plan partners.

El Camino Health Medical Network

FY23 ECHMN Performance Dashboard

Domain	Measure	Baseline FY22	FY23 Target	FY23 Q1
Clinical Excellence	Blood Pressure Management -primary care only	60%	65%	59%
	Diabetes Management-HbA1C <9% -primary care only	24%	<20%	57%
	Breast Cancer Screening -primary care only	68%	69%	73%
	Colon Cancer Screening -primary care only	57%	61%	63%
	Annual Flu Vaccination -primary care only	70%	71%	99%
	Medication Reconciliation -primary care only	98%	98.40%	96%
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	27.8 days
	Patient enrollment in my chart	63%	63%	81%
	Clinician response to patient message < 48 hours?	1.48 days	1.2 days	1.3 days
Experience	Primary Care LTR	83.2%	84.8%	82.1%
	Specialty Care LTR	86.8%	87.9%	81.6%
	Urgent Care LTR	78%	80.7%	72.9%

At or exceeding target
Missed target by 5% or less
Missed target by 5% or more

El Camino Health Medical Network

Clinical Excellence Domain

- ECHMN tracks over 25 quality measures for the CMS Merit-based Incentive Payment System (MIPS) program.
- ECHMN is making visible 6 of these on the FY23 Performance Dashboard.
- These 6 quality measures are based on patients that are attributed to our Primary care Providers.

29 Primary Care Providers
24 Physicians
5 Advance Practice Providers

Clinical Excellence Domain -Action Steps to Improve Performance

- **Blood Pressure Management**
  - Educate Provider and staff

- **Diabetes Control -HbA1C below 9%**
  - Quarter data does not accurately represent the current status – much higher than what we will achieve by end of calendar year.
  - CMS and health plans report the data on a calendar year.
  - Many of the patients seen in 1st quarter FY23, have already had a HbA1C test done, so they met the measure for calendar year.
  - Just to demonstrate, calendar year to date performance is 31%.

Dependable and Convenient Domain- Action Steps to Improve Performance

- Template redesign and scheduling guidelines
- Implementation of FastPass across specialties
- Accelerated Provider recruitment

Experience Domain – Action Steps to Improve Performance

- Replacement of per diem and contract staff with permanent position.
- New orientation program for new employees
- Expanded training and development for Call Center and Clinic staff

Questions?