El Camino Health

AGENDA

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

Monday, August 2, 2021 – 5:30pm

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

PURSUANT TO STATE OF CALIFORNIA EXECUTIVE ORDER N-29-20 DATED MARCH 18, 2020, El CAMINO HEALTH **WILL NOT BE PROVIDING A PHYSICAL LOCATION FOR THIS MEETING**. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 942 8066 9048#. 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**	George O. Ting, MD Quality Committee Vice Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	George O. Ting, MD Quality Committee Vice Chair		**information** **5:32 – 5:33**
3.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	George O. Ting, MD Quality Committee Vice Chair	*public comment*	**motion required** **5:33 – 5:43**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (06/07/2021) ***Information*** b. FY21 Enterprise Quality Dashboard c. Report on Board Actions d. Quality Committee Follow-Up Tracking			
4.	**CHAIR'S REPORT** a. FY 2022 Pacing Plan	George O. Ting, MD Quality Committee Vice Chair		**discussion** **5:43 – 5:53**
5.	**PATIENT STORY**	Mark Adams, MD, CMO		**discussion** **5:53 – 5:58**
6.	**ECHMN QUALITY REPORT**	Vince Manoogian, Interim President ECHMN Ute Burness, RN, VP of Quality & Payor Relations ECHMN	*public comment*	**discussion** **5:58 – 6:28**
7.	**QUARTERLY BOARD QUALITY DASHBOARD REPORT**	Mark Adams, MD, CMO	*public comment*	**discussion** **6:28 – 6:58**
8.	**PUBLIC COMMUNICATION**	George O. Ting, MD Quality Committee Vice Chair		**discussion** **6:58 – 7:01**

A copy of the agenda for the Regular Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at (650) 988-8483 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
9.	**ADJOURN TO CLOSED SESSION**	George O. Ting, MD Quality Committee Vice Chair	*public comment*	**motion required 7:01 – 7:02**
10.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	George O. Ting, MD Quality Committee Vice Chair		**information 7:02-7:03**
11.	**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 (06/07/2021)	George O. Ting, MD Quality Committee Vice Chair		**motion required 7:03 – 7:04**
12.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: **Q4 QUALITY AND SAFETY REVIEW**	Mark Adams, MD, CMO		**motion required 7:04 – 7:14**
13.	*Health and Safety Code Section 32155* **MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, CMO		**motion required 7:14 – 7:24**
14.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: **SERIOUS SAFETY EVENT/RED ALERT REPORT** (verbal report out)	Mark Adams, MD, CMO		**discussion 7:24 – 7:29**
15.	**ADJOURN TO OPEN SESSION**	George O. Ting, MD Quality Committee Vice Chair		**motion required 7:29 – 7:30**
16.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	George O. Ting, MD Quality Committee Vice Chair		**information 7:30 – 7:31**
17.	**CLOSING WRAP UP**	George O. Ting, Quality Committee Vice Chair		**discussion 7:31 – 7:36**
18.	**ADJOURNMENT**	George O. Ting, MD Quality Committee Vice Chair	*public comment*	**motion required 7:36 – 7:37**

Next Meeting: September 7, 2021, October 4, 2021, November 1, 2021, February 7, 2022, March 7, 2022, April 4, 2022, May 2, 2022, June 6, 2022

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, June 7, 2021
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
George O. Ting, Vice Chair**
Terrigal Burn, MD**
Alyson Falwell**
Michael Kan, MD**
Apurva Marfatia, MD**
Jack Po, MD**
Krutica Sharma, MD**
Melora Simon**

Members Absent
Julie Kliger, MD, Chair

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order at 5:30pm by Vice Chair Ting. A verbal roll call was taken. Dr. Po and Ms. Simon were not present during roll call. All other members were present at roll call and participated telephonically. A quorum was present pursuant to State of California Executive Orders n-25 dated March 12, 2020 and N-29-20 dated March 18, 2020.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Vice Chair Ting asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Vice Chair Ting asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. Dr. Po and Ms. Simon joined the meeting at 5:33pm during the Consent Calendar. **Motion**: To approve the consent calendar. (a) Minutes of the Open Session of the Quality, Patient Care and Patient Experience Committee Meeting (05/03/21). For information (b) Progress Against FY21 Committee Goals; (c) FY21 Enterprise Quality Dashboard; (d) Report on Board Actions; (e) Quality Committee Follow-Up Tracking; (f) Article of Interest. **Movant**: Burn **Second**: Marfatia **Ayes**: Burn, Falwell, Kan, Marfatia, Po, Sharma, Simon, Ting **Noes**: None **Abstain**: None **Absent**: Kliger **Recused**: None	***Consent Calendar approved***
4. CHAIR'S REPORT	The Board has reviewed financials and had elections. Lanhee Chen remains Chair, Bob Rebitzer is the Vice Chair, and Julia Miller is the Secretary/Treasurer. The Board is still undergoing strategic planning efforts with McKinsey.	
5. PATIENT STORY	Cheryl Reinking, DNP, RN NCA-BC, CNO, presented a patient's story from an El Camino Hospital employee. This employee was complimentary of the care she received, but she had a bad experience with patient registration. The person in front of her in line was taking a lot of time. Ms.	

	Reinking believes that the patient registration team can have more situational awareness and make sure all patients are being cared for efficiently. The patient registration team took this situation to heart and are making the proper improvements in this area. Ms. Reinking also reported that the other area of concern this same patient had was related to her diabetic management. This patient has been a Type 1 Diabetic for 34 years and had just had surgery. It was concerning to find out that after the surgery, the patient's blood sugar was above 300. The patient knew how to manage her sugars, but they were not being managed properly post-operation. This case has been referred to the Diabetic Management Committee. The patient is an El Camino Hospital employee and she agreed to come talk to this group about her experience. It was also reported that there would be an in-depth chart review to understand what staff could have done better and what can be done, in a broader sense, for post-operative patients in the future.	
6. READMISSION DASHBOARD	Mark Adams, MD, CMO reported the O/E ratio for FY21 (End of Q3) was 0.86 which is good because El Camino Hospital's overall target is 0.93 for all the readmission categories. (The dashboard here is limited to the seven diagnoses used by CMS for the readmission reduction penalty program.) Dr. Adams reported that the two categories that saw a spike were the Coronary Artery Bypass Graft and Total Hip Arthroplasty and/or Total Knee Arthroplasty. Dr. Adams clarified that those are the two categories that have a higher variance because 1 or 2 readmissions have a larger effect on the O/E ratio. Those cases will be reviewed to see what can be done differently. Dr. Adams also clarified that each of the seven (7) categories need to meet the index or else the hospital is penalized. El Camino Hospital almost avoided the penalty, but 80% of hospitals are penalized. Dr. Adams also clarified that if a patient is readmitted, the readmission counts toward the category's O/E Ratio, even if the readmission is completely unrelated to the initial cause of hospitalization.	
7. PSI REPORT	Dr. Adams reported that the composite PSI score for FY21 (Q1-3) is very good. The categories in which El Camino Hospital was over the mean were Pressure Ulcer, Iatrogenic Pneumothorax, Perioperative Hemorrhage or Hematoma, OB Trauma Vaginal Delivery with Instrument, and OB Trauma Vaginal Delivery without Instrument. Dr. Adams mentioned that the Pressure Ulcer was likely higher due to the abundance of patients with Covid-19 who required oxygen delivery devices to be put on their face. The Iatrogenic Pneumothorax was an isolated incident in one patient with bilateral pneumothoraces. Dr. Adams reported that the OB Trauma Vaginal Delivery with and without instrument categories remain above average with efforts being made to try to lower them.	
8. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN	Dr. Adams compared the IBM Watson Top 100 score from 2018 and 2020. The 2018 score, at the time, left many with questions about how to improve, but the 2020 score shows that El Camino Hospital had the most improvement according to IBM Watson's metrics. They ranked #1 within the Top 100 in performance improvement. **Motion**: To approve the Quality Assessment and Performance Improvement Plan. **Movant**: Po **Second**: Sharma **Ayes**: Burn, Falwell, Kan, Marfatia, Po, Sharma, Simon, Ting **Noes**: None **Abstain**: None	***Quality Assessment and Performance Improvement Plan Approved***

	Absent: Kliger **Recused**: None	
9. PUBLIC COMMUNICATION	None.	
10. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session. **Movant**: Burn **Second**: Po **Ayes**: Burn, Falwell, Kan, Marfatia, Po, Sharma, Simon, Ting **Noes**: None **Abstain**: None **Absent**: Kliger **Recused**: None	***Adjourned to closed session at 6:15pm***
11. AGENDA ITEM 16 RECONVENE OPEN SESSION/ REPORT OUT	Open Session reconvened at 6:59pm. Agenda items 11-15 were covered in closed session. During the closed session, the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (05/03/2021), Quality Council Minutes, and Medical Staff Credentialing and Privileges Report.	
12. AGENDA ITEM 17: CLOSING WRAP UP	None.	
13. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 7:01 pm. **Movant**: Sharma **Second**: Marfatia **Ayes**: Burn, Falwell, Kan, Marfatia, Po, Sharma, Simon, Ting **Noes**: None **Abstain**: None **Absent**: Kliger **Recused**: None	***Meeting adjourned at 7:01pm.***

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

_____
Julie Kliger, MPA, BSN
Chair, Quality, Patient Care and Patient Experience Committee

El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Catherine Carson, MPA, BSN, CPHQ, Sr. Director Quality
Date: August 2, 2021
Subject: FY21 Enterprise Quality, Safety, and Experience Dashboard

Summary:

1. Situation: The Enterprise Quality, Safety, and Experience dashboard is used throughout the organization to illustrate, track, and communicate a key set of metrics to align the quality, safety, and experience improvement work. These key metrics are selected based on a careful review of the organizational incentive goals, strategic goals, and areas of concern based on standardized benchmarks. These are not the only metrics that are tracked but represent the highest priority for the organization.

- **A.** Provide the Committee with a snapshot of the FY 2021 metrics monthly with trends over time and compared to the actual results from FY2020 and the FY 2021 goals.
- **B.** Annotation is provided to explain each metric.

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

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

4. Assessment:

- **A.** Readmission Index increased with an increased # of readmissions to 111.
- **B.** Three SSEs assigned by team review for April: 1 SSI, 1 moderate sedation case, 1 failure to monitor IV line.
- **C.** Mortality Index decreased from May to 0.76 with fewer deaths and 1 COVID death.
- **D.** HCAHPS Likelihood to Recommend decreased with continued pressure from COVID restrictions.
- **E.** Only 1 C.Diff HAIs for June, maintaining metric below target.
- **F.** 2 SSIs in June from Los Gatos.
- **G.** Sepsis mortality Index dropped from May, 59% of all mortalities were due to Sepsis.
- **H.** PC-01 spiked to 9%, due to one case in Los Gatos.
- **I.** PC-02, Cesarean Birth increased significantly in Mountain View.
- **J.** Patient Throughput will continue in FY22, focusing on meeting a national benchmark. See additional detailed comments in the annotation of the report

5. Other Reviews: None

6. Outcomes:

Suggested Committee Discussion Questions: None

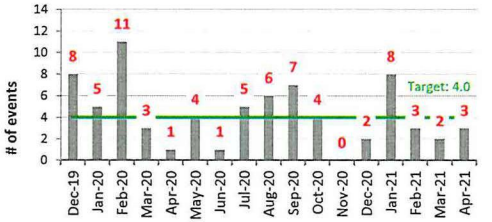
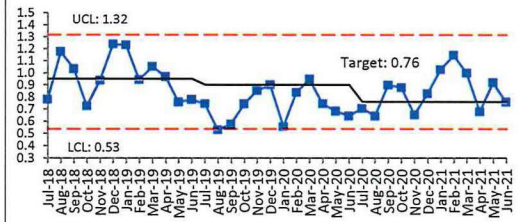
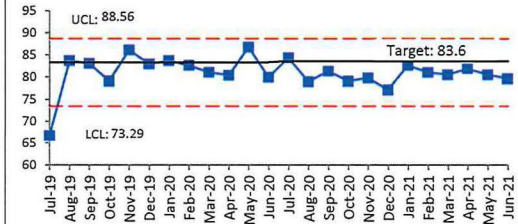
List of Attachments: August 2021 Enterprise Quality, Safety, and Experience Dashboard, April data unless otherwise specified - final results

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

June 2021 (unless otherwise specified)

Month to Board Quality Committee:
August, 2021

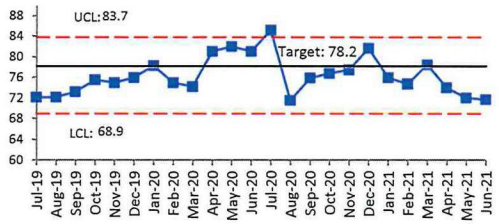
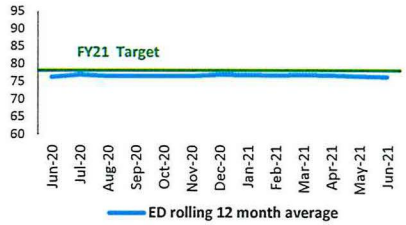
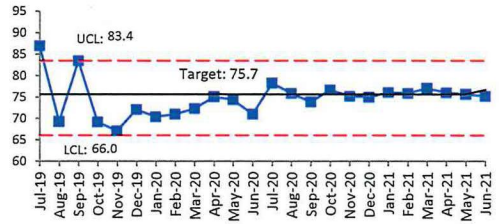
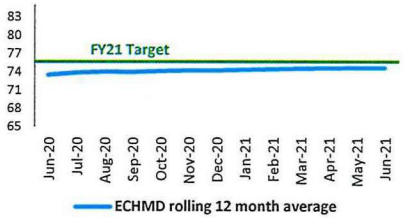
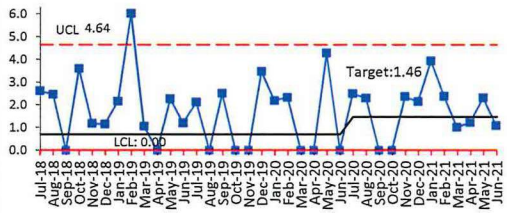
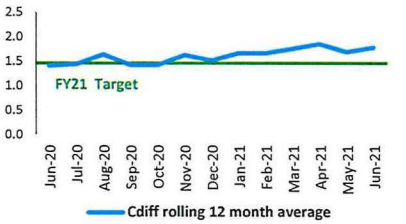
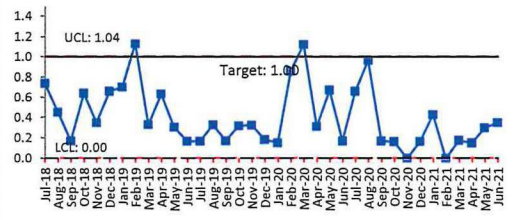
		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of *available* data)	Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** *Observed/Expected* *Premier Standard Risk Calculation Mode* ***Latest data month: May 2021*	0.94 (7.67%/8.16%)	0.92 (7.68%/8.32%)	0.96	0.93		
2	*Organizational Goal **Serious Safety Event Rate (SSER)** # of events/ (FYTD Rate per 10,000 Acute Adjusted Patient Days) ****Latest data month: April 2021*	3	3.24 (73/225108)	4.28	4.0		
3	* Strategic Goal **Mortality Index** *Observed/Expected* *Premier Standard Risk Calculation Mode* *Latest data month: Jun 2021*	0.76 (1.50%/1.99%)	0.86 (1.87%/2.18%)	0.74	0.76		
4	*Organizational Goal **IP Enterprise - HCAHPS Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.', Unadjusted** *Latest data month: June 2021*	79.6	80.3	83.1	83.6		

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

June 2021 (unless otherwise specified)

Month to Board Quality Committee:
August, 2021

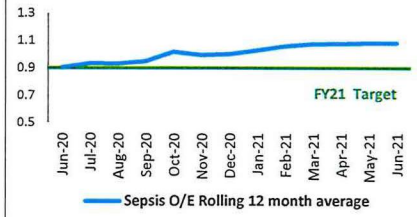
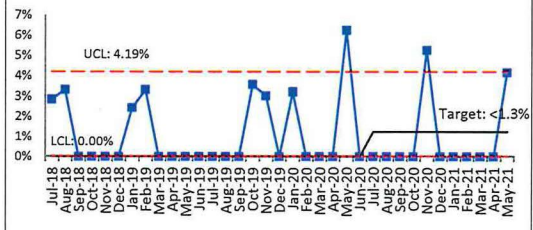
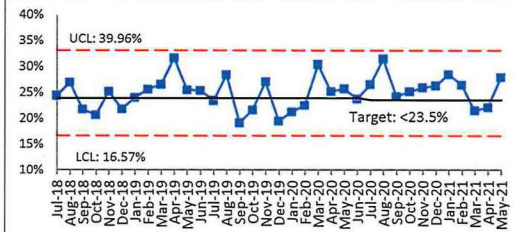
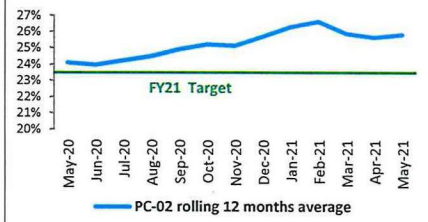
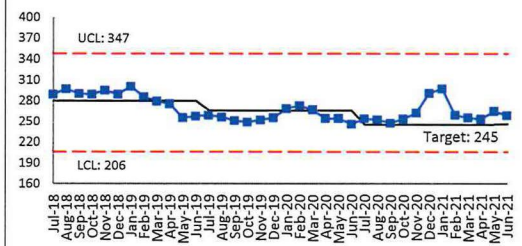
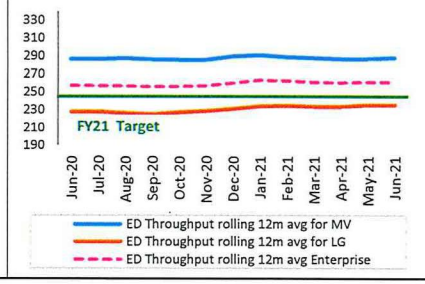
		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of *available* data)	Rolling 12 Month Average
		Latest month	FYTD				
5	* Organizational Goal **ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Unadjusted** *Latest data month: June 2021*	71.8	75.3	75.7	78.2		
6	* Organizational Goal **ECH MD : Likelihood to Recommend Care Provider** (SVMD only) **Top Box Rating of "Yes. Definitely Likely to Recommend."%, Unadjusted** *Latest data month: June 2021*	75.2	76.0	73.2	75.7		
7	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Latest data month: June 2021*	1.08 (1/9225)	1.78 (19/106990)	1.46	<= 1.46 (MV: 10/ LG: 3)		
8	*Organizational Goal **Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Latest data month: June 2021*	0.35 (2/568)	0.30 (21/7016)	0.36	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

June 2021 (unless otherwise specified)

Month to Board Quality Committee:
August, 2021

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of **available** data)	Rolling 12 Month Average
		Latest month	FYTD				
9	**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)* *Latest data month: June 2021*	1.10 (12.98%/11.83%)	1.08 (12.86%/11.87%)	0.98	0.90		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) **Latest data month: May 2021	MV: 0.0% (0/13) LG: 9.1% (1/11) **ENT: 4.2%** (1/24)	MV: 0.44% (1/226) LG: 1.4% (1/72) **ENT: 0.67%** (2/298)	MV: 1.47% (5/341) LG: 0.00% (0/48) **ENT: 1.29%** (5/389)	1.3%		
11	**PC-02: Cesarean Birth** (lower is better) **Latest data month: May 2021	MV: 30.9% (38/123) LG: 16.1% (5/31) **ENT: 27.9%** (43/154)	MV: 27.5% (383/1395) LG: 20.5% (66/322) **ENT: 26.15%** (449/1717)	MV: 24.7% (412/1665) LG: 18.9% (48/253) **ENT: 23.9%** (460/1918)	23.5%		
12	***Strategic Goal** **Patient Throughput- Median Time from Arrival to ED Departure** *(excludes psychiatric patients, patients expired in the ED, Newborns, and excludes transfer between sites)* *Latest data month: June 2021*	MV: 295 min LG: 223 min **Ent: 259 min**	MV: 288 min LG: 239 min **Ent: 264 min**	MV: 304 min LG: 263 min **Ent: 284 min**	MV: 263 min LG: 227 min **Ent: 245 min**		

** PC-01, PC-02 and Readmissions data are available up to March 2021

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

Report updated: 7/23/21

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee
From: Stephanie Iljin, Supervisor of Executive Administration
Date: August 2, 2021
Subject: Report on Board Actions

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

Summary:

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

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

3. Background: Since the last time we provided this report to the Quality Committee, the Hospital Board and the District Board have 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	June 23, 2021	- FY 2021 Period 10 Financials - FY 2022 Individual Executive Performance Incentive Goals - Medical Staff Credentials and Privileges Report - Quality Council Minutes - Amendment to the CEO Employment Agreement - Executive Performance Incentive and Benefit Plan Design - New Enterprise Anesthesia Services Agreement, MV Nightime Intersivist Servies Agreement, and Line of Credit Agreement - FY 2022 Master Calendar - FY 2022 Committee Goals - FY 2022 Committee Liaisons Appointments - FY 2022 Community Benefit Plan - FY 2022 Organizational Performance Incentive Plan Goals - FY 2021 Period 9 Financials - Infection Control Medical Director Agreement - Medical Staff Report - MV Major Projects Update
ECHD Board	June 17, 2021	- FY22 Community Benefit Plan Study Session

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
	June 29, 2021	- ECH FY 2022 Budget - ECHD FY 2022 Budget - ECHD FY 2022 Pacing Plan - District Capital Outlay Funds - Resolution 2021-08 FY 2022 Regular Meeting Dates - Resolution 2021-09 Granting Utility Easement for EV Charging Stations - Resolution 2021-10 Establishing Tax Appropriation Limit for FY 2022 (Gann Limit) - ECHD Covid-19 Community Testing Program - FY 2022 Community Benefits Plan - FY 2022 Community Benefits Advisory Liaison Appointment - District Board Officers Election: o Chair – Miller, Vice-Chair- Fung, Secretary/Treasurer - Somersille
Executive Compensation Committee	N/A	
Compliance Committee	N/A	
Finance Committee	N/A	

List of Attachments: None.

Suggested Committee Discussion Questions: None.

Quality Committee Follow up Item Tracking Sheet (07/23/2020)

#	Follow Up Item	Date Identified	Owner(s)	Status	Date Complete
1	Bring "negative" (not only positive) patient stories for discussion	11/4/2019	CR	Noted in Pacing Plan 12/2/19 going forward	Ongoing
2	Add control limits to Annual PI Reports	11/4/2019	CC/MA	Will be added to future reports	Ongoing
3	Look deeper into the the sytem for non-nursing related issues for the patient stories	12/2/2019	CR	Open	Ongoing
4	Cover Memos - Make sure to state what the staff wants from the committee/how the committee can be helpful and provide discussion questions	12/2/2019	Executive Team	Open	Ongoing

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

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

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

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

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP, RN, NEA-BC
Date: August 2, 2021
Subject: Patient Experience feedback from Discharge Phone Call

Purpose: To provide the Committee with written patient feedback that is received via a new method for receiving patient feedback through the discharge phone call process implemented in June 2021. The information provided in the feedback is an exact quote provided by the patient during the new phone call program.

Summary:

1. Situation: These comments are from a patient who received a discharge phone call utilizing our new process from Cipher Health. The discharge phone call program is intended to gain feedback from our patients soon after discharge. It allows ECH to address concerns immediately and to understand any post discharge concerns such as a lack of understanding of discharge instructions so we can intervene.
2. Authority: To provide insight into one patient's experience.
3. Background: This patient provided generally good feedback about nursing care and food. However, there was a concerning comment related to the new TV system called The Get Well Network.
4. Assessment: This feedback is helpful in validating what we have heard from other patients about the new TV system. The TV is very sophisticated technically and needs to be simplified for our patients with easy to understand instructions.
5. Other Reviews: None
6. Outcomes: The Get Well Network team and ECH activation team is working together to provide a simple set of instructions for the TV system and to optimize its user interface. The positive feedback provided through this discharge phone call will be provided to staff as well providing staff with positive patient experience stories which are motivating for the staff.
7. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. What is the purpose of the new discharge phone call program and what have you learned so far from the feedback?
2. What is your process for responding to patients when the feedback is concerning?

Comment From New Discharge Phone Call Program

“In general it was excellent, no problems at all. The nursing staff was the first class. Unfortunately I was there on Saturday and Sunday so there wasn't very many doctors around but there was enough.

The food was good

What you really ought to spend some time in writing up instructions on how to use that absurd television system at the hospital! It's ridiculous”

That is about all. Thank you!

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Vince Manoogian, Interim President ECHMN and Ute Burness, RN, VP of Quality, ECHMN
Date: July 21, 2021
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. HEDIS (Healthcare Effectiveness Data and Information set)
B. MIPS (Medicare Incentive Payment System)
C. NPS (net promoter score)

ECHMN has established true north pillars, one of which is quality and service. For quality, the goals are: achieve top decile HEDIS composite score by end of calendar year 2023 and achieve MIPS composite exceptional rating annually. While there are many more HEDIS measures, 8 key metrics have been selected based on importance to patient care, impact on financial reimbursement, and concordance with MIPS measures. The latest quarter results in the composite score is 3.4, which is up from the previous quarter of 3.2. The overall Fiscal Year 2021 score was 3.375 compared to a target of 3.0.

Fiscal Year 2022 overall target is 3.6 based on the same 8 key metrics.

Finally, the Net Promoter Score for ECHMN has shown a steady improvement. NPS is calculated by asking patients to rate on a 1 to 10 scale their likelihood to recommend. The percent of 9's and 10's is reduced by the number of 1's through 5's. (6, 7, and 8's do not count). FY 2021 Q4 is not available and will be reported at the next meeting.

ECHMN submitted the MIPS quality data in March, we are now awaiting the cost scores, and our final MIPS score for 2020. We should receive the information this fall.

5. Outcomes:

6. List of Attachments:

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

Suggested Committee Discussion Questions:

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

El Camino Health

System Quality Committee Report

Ute Burness, RN, VP of Quality & Payer Relations

August 2, 2021

Why is Quality Care Important to ECHMN?

- The ultimate goal of ECHMN is to deliver high quality care and keep our patients healthy
- High performance on these quality measures supports healthy patients
- Exceptional MIPS score increases Medicare revenue
- Opens doors for new opportunities for ECHMN
  - Increases clout with the payers and may increase reimbursement
  - Allows ECHMN to participate in risk arrangements
  - May attract new patients who research quality score

8 HealthCare Outcomes Metrics

- ECHMN monitors 8 HealthCare Outcome Metrics for quality performance improvement
- These measures were picked because they are used by Centers for Medicare and Medicaid (CMS) and National Commission for Quality Assurance (NCQA)
- 4 measures are high priority measures and 4 include specialty care measures
    - CMS has various measures that they consider high priority measures, which include the following:
        - Documentation of Medications in the Medical Record
        - Diabetes Hemoglobin A1C control
        - Controlling High Blood Pressure
        - Falls Risk Screening

The History of the Composite Score

- The decision was made to select 8 measures, they were selected because they provided the most benefit to our patients, were being done by a majority of the specialist and closely aligned with the type of patients ECHMN served
- The targets were based on the MIPS national benchmarks published by CMS, as well as looking at the current performance of ECHMN
- The organization wanted a “rolled up” single “composite” score for all of the eight measures
- The National Benchmarks are based on a 10 deciles system. ECHMN decided to make every two deciles count as 1 point (for example, deciles 1&2 = 1 point, deciles 3&4 = 2 points, deciles 5&6 = 3 points, deciles 7&8 = 4 points, deciles 9&10= 5 points)
- The points were then averaged across all eight measures

CMS 68 – Documentation of Current Medications in the Medical Record

- **Description:** Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.
- **FY 21 Target:** 89% (5th decile, 3 points)
- **FY 21 Performance:** 89.5% (5th decile, 3 points)
- **FY 22 Improvement Activities:**
  - *Hard stop has been implemented within EPIC*
  - *Clinical staff must address the issue during charting*
  - *The chart can't be closed without reviewing medications*

Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Documentation of Current Medications in the Medical Record	89.1	`	6.5 - 55.9	66 - 88.8	88.9 - 97.3	97.4 - 99.7	99.8 - 99.9	--	--	100

El Camino Health Medical Network

CMS 69 – Preventative Care and Screening: Body Mass Index (BMI) and Follow Up Plan

- **Description:** Percentage of patients aged 18 and older with a BMI documented within the current encounter or during the previous 12 months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous 12 months of the current encounter. Normal parameters: =>18.5 and <25 kg/m2
- **FY 21 Target:** 47% (6th decile, 3 points)
- **FY 21 Performance:** 46.75% (6th decile, 3 points)
- **FY 22 Activities:**
  - *Hard Stop implemented within EPIC*
  - *MA's retrained on the importance of taking height and weight at each visit and where to document the BMI*
  - *The chart can not be closed with the BMI being in the chart.*

Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Documentation of Current Medications in the Medical Record	89.1	`	6.5 - 55.9	66 - 88.8	88.9 - 97.3	97.4 - 99.7	99.8 - 99.9	--	--	100

El Camino Health Medical Network

CMS 122 – Diabetes: Hemoglobin A1C Poor Control

- **Description:**. Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.
- **FY 21 Target:** <29%(10th decile, 5 points)
- **FY 21 Performance:** 30.75% (10th decile, 5 points)
- **FY 22 Improvement Activities:**
  - *Quality Department will provide list of all diabetics patients to the PCP's*
  - *Providers need to work the Best Practice Alerts (BPA's) to make sure they are closing all care gaps*
  - *PCP's will need to order HbA1c tests for any patient who has not had a test within this calendar year*
  - *For the patients with HbA1c over 9, bring patient in for a visit and assess their plan to get the HbA1c down below 9 and then do repeat test before the end of the year*

Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) - Inverse Metric (lower is better)	45.7	>99.5	99.5	99.4 - 92.6	92.5 - 74.5	74.4 - 59.1	59- 46.9	46.8 - 38	37.9 - 31.4	< 31.4

CMS 125 – Breast Cancer Screening

- **Description:** Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period
- **FY 21 Target:** 47% (5th decile, 3 points)
- **FY 21 Performance:** 51.5% 5th decile, 3 points)
- **FY 22 Improvement Activities:**
  - *Quality Department will provide list of all patients that meet the criteria for needed mammogram to the PCP and/or Specialist*
  - *Providers will need to order the mammogram and once the test results come back, they need to document in the Health Maintenance section of EPIC*
  - *For those patients that do not have a PCP, ECHMN will designate one of the providers to order the mammogram for the patient*

Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Breast Cancer Screening	48.4	<0.3	0.3 - 7.3	7.3 - 27.2	27.3 - 51.5	51.6 - 69.3	69.4 - 81.4	81.5 - 88.2	88.3 - 98.5	>98.5

CMS 130 – Colorectal Cancer Screening

- **Description:** Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria: Fecal occult blood test (FOBT) during the measurement period, Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period, Colonoscopy during the measurement period or the nine years prior to the measurement period, FIT-DNA during the measurement period or the two years prior to the measurement period or CT Colonography during the measurement period or the four years prior to the measurement period
- **FY 21 Target:** 45% (5th decile, 3 points)
- **FY 21 Performance:** 44.5% (5th decile, 3 points)
- **FY 22 Improvement Activities:**
  - *Quality Department will provide list of patients who meet the criteria for needed screening to the PCP*
  - *PCP will need to order one of the approved tests and/or send the patient to a specialists to have the study done*

Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Colorectal Cancer Screening	45.0	<0.1	0.1 - 2.5	2.6 - 19.3	19.4 - 45.6	45.7- 70	70.1 - 84.5	84.6 - 90.8	90.9 - 99.4	>=99.4

CMS 138 – Preventative Care and Screening Tobacco Use: Screening and Cessation Intervention

- **Description:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months AND who received tobacco cessation intervention if identified as a tobacco user
- **FY 21 Target:** 94% (7th decile, 4 points)
- **FY 21 Performance:** 98.25% (8th decile, 4 points)
- **FY 22 Improvement Activities:**
  - *Quality Department to provide list of patients that meet criteria for needed screening and intervention to the PCP*
  - *PCP needs to screen for tobacco use and document such in the chart*

Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	59.9	<0.9	0.9 - 7.2	7.3- 24.1	24.2 - 74	74.1 - 90.2	90.3 - 97.1	97.1 - 99.9	--	100

CMS 139 – Falls – Screening for Future Fall Risk

- **Description:** Percentage of patients 65 years of age and older who were screened for future fall risk at least once during the measurement period
- **FY 21 Target:** 56 (5th decile, 3 points)
- **FY 21 Performance:** 80.75% (6th decile, 3 points)
- **FY 22 Improvement Activities:**
  - *Quality Department will provide PCP with a list of patients that meet criteria for needed screening*
  - *PCP to complete the fall risk screening tool during the visit and to document in EPIC*

Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Falls: Screening for Future Fall Risk	56.6	<0.04	0.04 - 1.3	1.4 - 21.6	21.7- 65.3	65.3 - 90.3	90.4 - 98.1	98.2 - 99.5	99.6 - 99.9	100

CMS 169 – Controlling High Blood Pressure

- **Description:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period
- **FY 21 Target:** 63% (7th decile, 4 points)
- **FY 21 Performance:** 57.75% (6th decile, 3 points)
- **FY 22 Improvement Activities:**
  - *Quality Department will provide list of all patients who meet criteria to the PCP*
  - *Consider having Blood Pressure Clinics in the Fall /Winter*
  - *For those patients that their Blood Pressure is still too high, bring the patient in for a visit to discuss their treatment plan*

Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Controlling High Blood Pressure	63.6	<20	20 - 29.9	30 - 39.9	40 - 49.9	50 - 59.9	60 - 69.9	70 - 79.9	80 - 89.9	>= 90

Fiscal Year 2021 – HealthCare Outcomes Composite Score

Measurement	FY 21 Target	FY 21 Performance	FY 2021 Score
Composite Score	3.0	3.375	
CMS 68 - Documentation of Current Medications in the Medical Record	89%	89.5%	3
CMS 69- Prevention and Screening: Body Mass Index (BMI) Prevention and Follow Up Plan	47%	46.75%	3
CMS 122- Hemoglobin A1C Poor Control (lower number is better)	<29%	31%	5
CMS 125- Breast Cancer Screening	47%	51.5%	3
CMS 130 – Colorectal Cancer Screening	45%	44.5%	3
CMS 138 – Prevention and Screening: Tobacco Use-Screening and Cessation Intervention	94%	98.25%	4
CMS 139- Fall Risk Screening	56%	80.75%	3
CMS 165- Controlling High Blood Pressure	63%	57.75%	3

Fiscal Year 2022 Quality Metrics Goal and Composite Score Goal

Measurement	FY 22 Target	FY 21 Target
CMS 68 - Documentation of Current Medications in the Medical Record	91 %	89%
CMS 69- Prevention and Screening: Body Mass Index (BMI) Prevention and Follow Up Plan	53 %	47%
CMS 122- Hemoglobin A1C Poor Control (lower number is better)	<29 %	<29%
CMS 125- Breast Cancer Screening	55 %	47%
CMS 130 – Colorectal Cancer Screening	45 %	45%
CMS 138 – Prevention and Screening: Tobacco Use-Screening and Cessation Intervention	94 %	94%
CMS 139- Fall Risk Screening	83 %	56%
CMS 165- Controlling High Blood Pressure	57%	63%
Composite Score	3.6	3.0

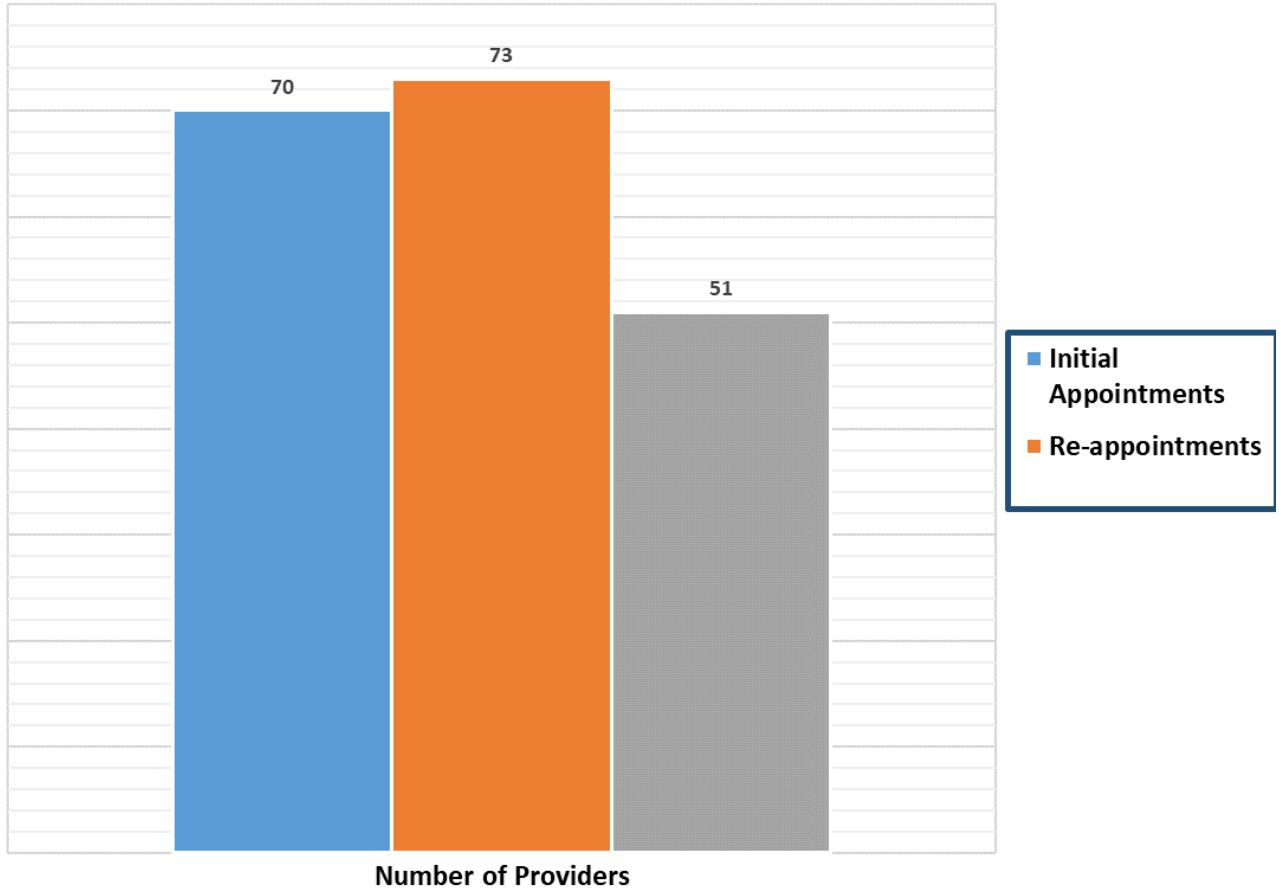
Additional Activities Being Monitored by the Quality Committee

- The quality committee also oversees the activities of the Credentialing Committee.
- The credentialing department has been busy with the pre delegation and annual delegation audits and have passed all audits.
- The quality committee also monitors the complaints and grievances of ECHMN.

Credentialing Delegation Status – Fiscal Year 2021

Plan		Date	Status
Aetna	Annual Audit	June 3	Approved for continued delegation of credentialing
Anthem	Pre-delegation Audit	May 24	Score: 100% Recommend delegation of credentialing and re-credentialing
Blue Shield	Pre-delegation Audit	April 8	Score: 100% Recommend delegation of credentialing and re-credentialing
Caremore	Annual Audit	June 22	Score: 100% Continued full credentialing and re-credentialing delegation
HealthNet	Annual Audit	June 10	Score: 100% Continued full credentialing and re-credentialing delegation
United HealthCare	Annual Audit		Pending
Valley Health Plan	Annual Audit		Pending

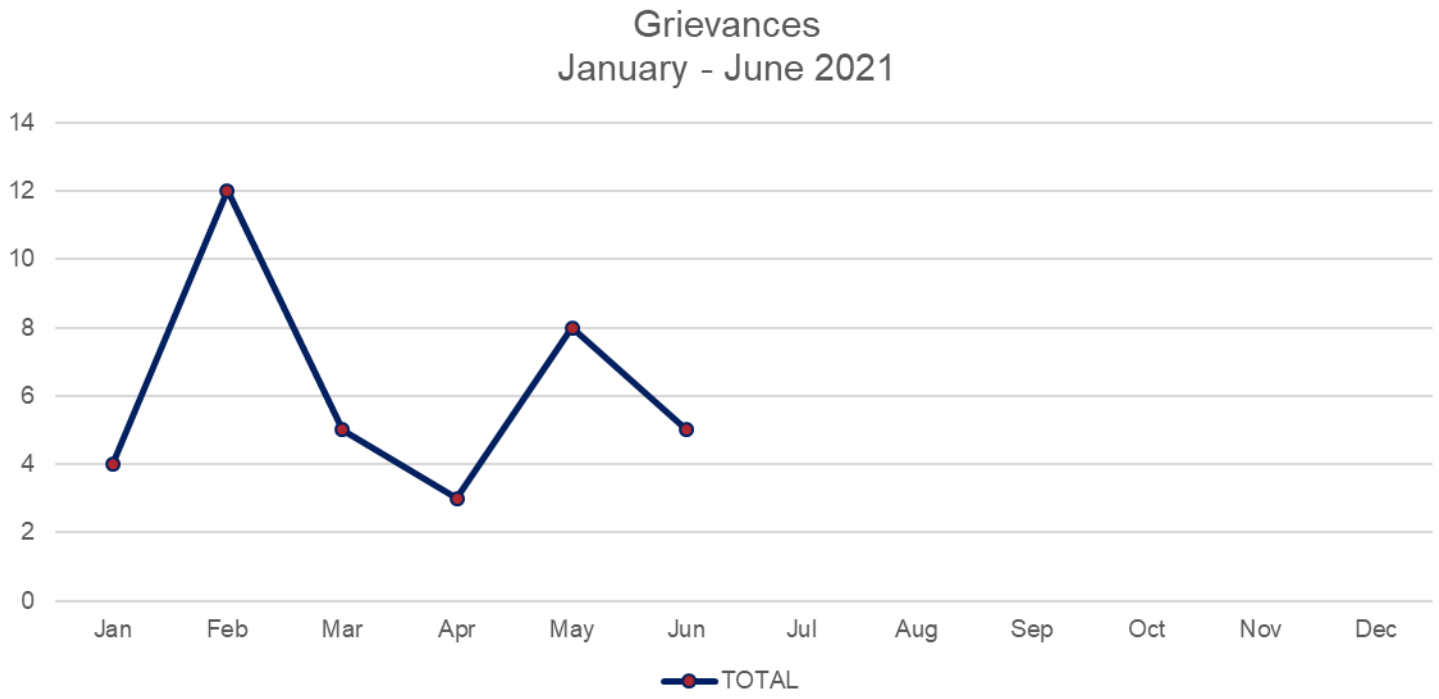
ECHMN has received Credentialing Delegation status from many of our large payers. Credentialing Delegation allows ECHMN to credential and re-credential the providers and it also makes the provider enrollment process with the Health Plans much quicker. As you can see from the table ECHMN has been successful in the initial and annual audits for Credentialing Delegation



The table shows the number of providers that have been credentialed for their initial and for reappointment. The Grey bar shows the number of providers that have separated from ECHMN. These numbers include all of the downstream providers that are contracted with ECHMN.

El Camino Health Medical Network

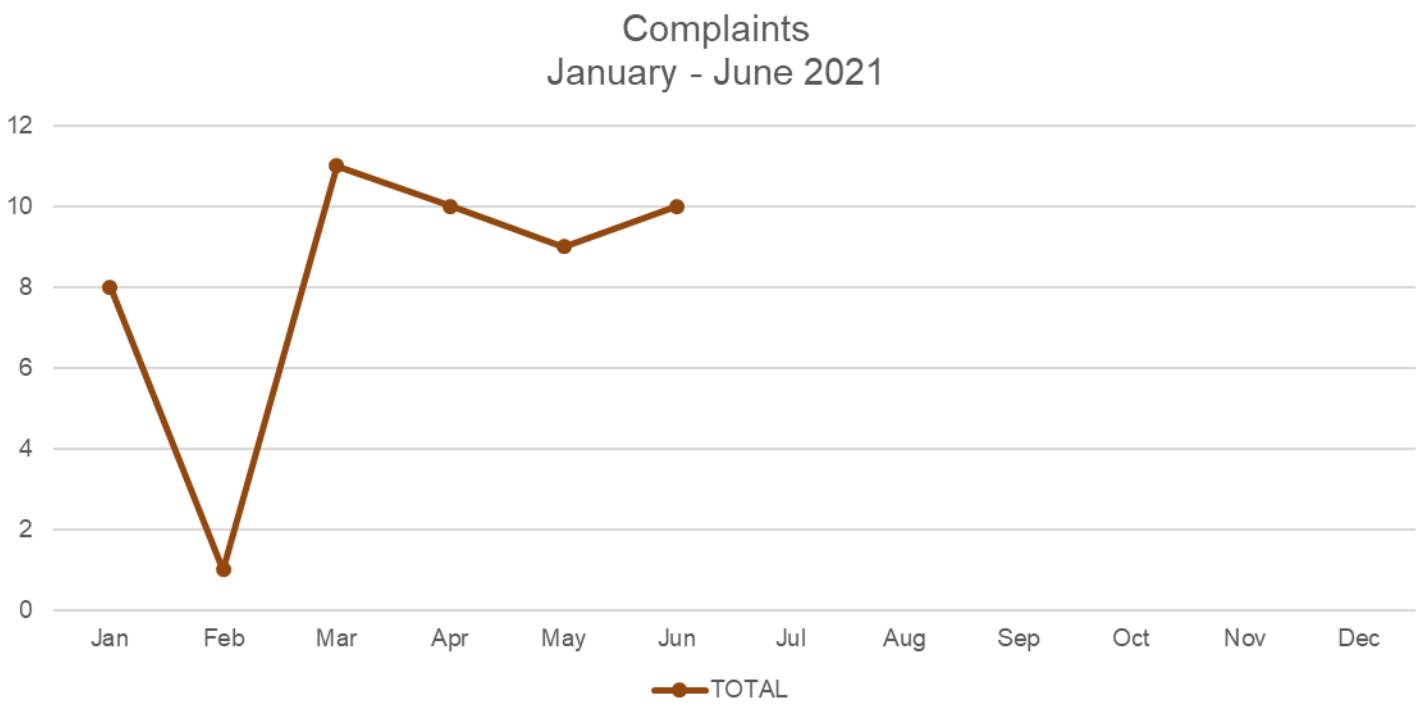
Grievances: January – June 2021



Grievances are a written complaint from a member that come through the health plans. ECHMN tracks and responds to all grievances

El Camino Health Medical Network

Complaints: January – June 2021



Complaints are investigated, tracked, and trended

Questions and Comments

Why Is Quality Care Important to ECHMN?

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: August 2, 2021
Subject: Board Quality and Safety Dashboard

Purpose: To review the Q4 Board Quality and Safety Dashboard.

Summary:

1. Situation: The Quality Committee reviews the quarterly Board Quality and Safety Dashboard preceding submission to the Board.

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

3. Background: This dashboard is designed to provide the Board with a standardized high level snapshot of overall quality and safety. It is provided on a quarterly basis. Each quarter is scored separately with a FYTD21 total presented in the last column. This dashboard is based on the STEEEP definition of quality and safety that is a national standard adopted by the IHI (Institute for Healthcare Improvement).

4. Assessment: The Board's Quality Committee will continue to review the more sophisticated control charts and more detailed analysis of topics requiring attention but the Board will rely on this dashboard as included in the Quality Committee report. The intent is to review those areas of potential concern (in red) and are noted below according to the Quality Domain:

A. Safe Care:

i. Mortality index has decreased to .79 for the quarter and .86 FYTD. This is lower than target which was set as .76 which is the most recent top performers score. However, it is significantly less than 1.0 which is desirable.

ii. Sepsis mortality index has decreased this quarter but will end at 1.08 FYTD. There has been an upward shift nationally as the current top tier performers are now at 1.05. There is some contribution from COVID-19 cases but that's not the only explanation. Some experts are indicating the hesitance to seek care may be contributing to more advanced sepsis cases where salvage is more difficult.

iii. CLABSI: 0 this quarter and FYTD is 0.5 based on a few instances in Q2 and Q3. Efforts have been made to reinforce the application of the central line bundle for placement and the ongoing care of the lines.

iv. C. diff. will end slightly above target (1.46) at 1.78.

B. Timely:

i. All three ED measures continue above target. Identification of COVID-19 patients including testing continue to slow throughput as well as a resurgence of more ED visits now approaching pre-pandemic levels.

C. Effective Care:

i. Readmission Index has returned to a level just below target which is a very positive trend.

ii. CMS SEP-1 Compliance rate: decreased in Q4 to 58.0% below internal goal of 86%; (CMS median rate is 60% across all hospitals) FYTD rate: 72.0%

iii. PC-02 C/S rate: this has remained steady but above target of 23.5%. There is a wide variation among practitioners with some well below target and some approaching 50%. Efforts are being made to counsel those above the target.

D. Efficient Care: No issues
E. Equitable Care: No issues
F. Patient-Centered Care:
   i. IP enterprise LTR and ED LTR remain below target at FYTD 80.3% and 75.3%, respectively. MCH LTR is also below target with FYTD 80.8%. (As a reminder, the IBM Watson Health Top 100 hospitals median IP LTR was 77%.)

5. Other Reviews: None

6. Outcomes: The Quality Committee will be in a position to report to the Board on the current state as of Q4 and FYTD.

List of Attachments:

1. Q3 STEEEP dashboard

Suggested Committee Discussion Questions:

1. Are there any questions regarding the "red" metrics?
2. Would the Committee like to use findings on this dashboard to drive agenda items for more in depth reviews going forward?
3. What additional supporting information would be useful to the Committee to assist in evaluating the metrics?
4. What educational support might be useful to convey to the Board to help with interpretation of this information?

El Camino Health

Month to Quality Committee of the Board: August 2021

Quarterly Board Quality Dashboard (STEEEP Dashboard) FYTD 21, Q4 (unless otherwise specified by *)

Quality Domain	Metric	Baseline	Target	Performance				
		FY 20	FY 21	FY21, Q1	FY21, Q2	FY21, Q3	FY21, Q4	FYTD21 Total
Safe Care	Risk Adjusted Mortality Index	0.74	0.76	0.75	0.79	1.06	0.79	**0.86**
	Sepsis Mortality Index	0.96	0.90	0.76	1.14	1.31	1.08	**1.08**
	Serious Safety Events Rate (SSER) (baseline Dec'19 to Jun'20)	4.28	4.00	3.98	3.35	3.54	**3.24	**3.24**
	Surgical Site Infections (SSI)	0.36	1.0 (SIR)	0.62	0.11	0.23	0.26	**0.30**
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	0.47	<= 0.48	0.51	0.71	0.00	0.26	**0.37**
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.15	<= 0.20	0.0	0.71	0.82	0.00	**0.5**
	Clostridium Difficile Infection (CDI) - HAI	1.46	<= 1.46	1.6	1.43	2.59	1.54	**1.78**
	Modified PSI-90 CMS HAC Reduction Program	0.919	0.90	0.898	0.815	1.034	0.809	**0.751**
Timely	Patient Throughput - ED Door to Admit Order	190 min	181 min	188 min	195 min	196 min	194 min	**193.5 min**
	Patient Throughput - Median Time Arrival to ED Departure	284 min	245 min	255 min	274 min	271 min	258 min	**264 min**
	ED Arrival to Direct Discharge for ED Patients	151 min	145 min	154 min	154 min	162 min	166 min	**159 min**
Effective	Risk Adjusted Readmissions Index	0.96	0.93	0.88	0.96	0.95	*0.86	**0.92**
	CMS SEP-1 Compliance Rate	70.9%	86%	67.6%	81.8%	80.5%	58.0%	**72.0%**
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	ENT: 1.3%	1.3%	0%	1.2% (1/85)	0.00%	*2.0%	**0.67%**
	PC-02 NTSV C-Section	ENT: 24.0%	23.5%	27.6% (142/514)	25.8% (120/466)	25.44% (115/452)	*25.26%	**26.2%**
	ECMN: CMS 165 Controlling High Blood Pressure	51.20%	<= 63%	58.0%	56.0%	59.0%	60.0%	**59.0%**
	ECMN: CMS 122 Diabetes Hemoglobin A1c Poor Control	43.30%	<= 45	27.0%	29.0%	32.0%	33.0%	**30.0%**
	HEDIS: Composite	NA	3.0	3.3	3.3	3.2	3.4	**3.3**
Efficient	Arithmetic Observed LOS/ Geometric Expected LOS	1.32	1.30	1.32	1.32	1.31	0.97	**1.23**
	MSPB-1 Medicare Spending per Beneficiary (CMS)	0.99 (CY 18)	0.99	0.99	None, updated annually in January	1.00	None, updated annually in January	**0.99**
Equitable	Hospital Charity Care Support	$20.5 mil	NA	$6.6 mil	$5.7 mil	$7.4 mil	$7.3 mil	**$19.7 mil**
	Clinic Charity Care Support	$44.3k	NA	$8.4k	$1.1k	$3.3k	$2.1k	**$14.9k**
	Language Line Unmet Requests (data collection started Q2)	0.34%	<1%	0.39%	0.64%	1.07%	0.77%	**0.72%**
	Length of Stay Disparity (Top 3 races) 40% patients did not report their race	Black: 4.05	NA	3.98	4.56	4.11	4.08	**4.00**
		White: 3.79		3.81	3.97	3.92	3.77	**3.89**
		Asian: 3.64		3.54	3.38	3.72	3.53	**3.57**
Patient-centered	IP Enterprise - HCAHPS Likelihood to Recommend	83.1	83.6	80.7	78.6	81.4	80.6	**80.3**
	ED - Likelihood to Recommend (PG)	75.7	78.2	73.9	78.7	76.5	72.6	**75.3**
	ECHMD - Likelihood to Recommend Care Provider (NPS)	73.2	75.7	76.2	76.0	76.4	75.7	**76.1**
	MCH - HCAHPS Likelihood to Recommend	84.1	84.6	82.9	78.2	83.4	79.5	**80.8**
	OAS - HCAHPS Likelihood to Recommend	84.7	86.4	83.5	86.1	86.1	86.47	**85.61**

Report updated 7/26/21

* data available up to FYTD 21 May only

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

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