El Camino Health

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

Monday, February 7, 2022 – 5:30pm
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

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

1-669-900-9128, MEETING CODE: 979 4617 4637#. No participant code. Just press #.

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Julie Kliger, Quality Committee Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 5:32 – 5:33**
3.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:43**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (12/06/2021) ***Information*** b. Report on Board Actions c. FY 22 Pacing Plan d. FY 22 Enterprise Quality Dashboard e. Article of Interest			
4.	**CHAIR'S REPORT**	Julie Kliger, Quality Committee Chair		**information 5:43 – 5:48**
5.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer		**discussion 5:48 – 5:53**
6.	**EL CAMINO HEALTH MEDICAL NETWORK REPORT**	Vince Manoogian, Interim President ECHMN Ute Burness, VP of Quality and Payer Relations		**discussion 5:53 – 6:13**
7.	**QUARTERLY BOARD QUALITY DASHBOARD REVIEW**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:13-6:33**
8.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**discussion 6:33-6:36**
9.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 6:36 – 6:37**

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
10.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 6:37-6:38**
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 (12/06/2021) b. Quality Council Minutes (12/01/2021) c. Quality Council Minutes (01/05/2022)	Julie Kliger, Quality Committee Chair		**motion required 6:38– 6:39**
12.	*Health and Safety Code Section 32155* **MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer		**motion required 6:39-6:49**
13.	*Health and Safety Code Section 32155* **Q2 FY22 QUALITY AND SAFETY REVIEW**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:49-6:59**
14.	*Health and Safety Code Section 32155* **PATIENT CONCERN FOLLOW UP**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:59-7:14**
15.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:14-7:15**
16.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		**information 7:15– 7:16**
17.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 7:16 – 7:19**
18.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:19 – 7:20 pm**

Next Meeting: 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, December 6, 2021
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

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

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order at 5:30 pm by Chair Julie Kliger. A verbal roll call was taken. Dr. Burn, Ms. Falwell, and Ms. Simone were not present during roll call. Ms. Simone joined at 5:36 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 Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	**Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (11/01/2021); For information: (b) Report on Board Actions, (c) FY 22 Pacing Plan, (d) FY 22 Enterprise Quality Dashboard (e) Quality Committee Follow-Up Tracking **Movant**: Ting **Second**: Sharma **Ayes**: Kliger, Kan, Marfatia, Po, Sharma, Somersille, Ting, **Noes**: None **Abstain**: None **Absent**: Burn, Falwell, Simone **Recused**: None	***Consent Calendar approved***
4. CHAIR'S REPORT	Chair Kliger summarized takeaways from the Study Session that occurred Wednesday, December 1st. During the Study Session, the presenter shared red flags that would help signify which Credentialing Privileging report cases should be pulled for further review. Once pulled for further review, the management team would summarize each case and include outside input from peer reviews and other outside sources.	

	We would like to get a list of red flags by the next committee meeting for the quality committee to review and agree upon.	
5. PATIENT STORY	Cheryl Reinking, CNO presented a positive letter we received from a Patient who visited the Los Gatos campus for surgery. This patient was thorough and explained what made her experience so positive. The Patient shared her whole process from when her surgery was scheduled through discharge. She shared that the staff explained things to her in a way she could understand. On the day of surgery, again, things were explained to her regarding her surgery and she was able to address concerns with the anesthesiologist based on a prior negative experience she had. She also expressed her appreciation for her care after the surgery. This patient sent a card to every person that she named in the letter along with a gift card.	
6. READMISSION DASHBOARD	Dr. Adams presented the Readmission Dashboard and noted that this dashboard tracks the Medicare Readmission Penalty Program specifically versus the Overall Readmission work. Dr. Somersille noted a significant decrease in COPD and Stroke readmissions and asked if this has been analyzed as to why this has decreased. Dr. Adams responded that it has not been analyzed but the work going into it is known and is continuously being improved. Actions he shared are post-acute care follow-ups, education, respiratory rehab center, and conversa. Dr. Marfatia shared that COPD readmission may be decreased due to self-isolation and masking. Dr. Adams expressed that this may be a management dashboard versus a Committee dashboard.	
7. PSI REPORT	Dr. Adams presented the PSI Report and highlighted that OB Trauma has gone down. Dr. Somersille requested analysis to show why certain metrics are improving. For example, having analysis on OB Patients (Massage Technique) - How many are doing that, rate of service, how often are they doing it. The protocol is not standardized. Dr. Adams stated he will pass this request on to the OB Department.	
8. REPORT ON MEDICAL STAFF PEER REVIEW PROCESS	Dr. Adams recapped the Staff Peer Review Process and expressed that the goal is to be fair, equitable, transparent, and have an understanding of the why for specific cases being reviewed. Dr. Somersille requested articles from high-performing healthcare institutions that show examples that this is a better process for peer review.	
9. SEPSIS MORTALITY INDEX	Chair Kliger gave a brief introduction sharing that the discussion will be around taking a deeper dive into the Sepsis Mortality Index and the change to the Sepsis target. She requested to the subject matter experts that the discussion addresses the processes, task force, etc.	

	Dr. Adams shared that the Sepsis target has not changed, it was only his personal target that changed due to not being aligned with the enterprise target. He further reviewed the Historical Perspective - Sepsis Mortality Trend: FY17-FY22 through end of September. Ms. Harkey reviewed the Sepsis program with the Committee as further detailed in the packet materials. Dr. Shin gave an overview of the Physicians role in the Sepsis Mortality Goal. A brief discussion ensued.	
10. PUBLIC COMMUNICATIONS	There were no comments from the public.	
11. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 7:04 pm. **Movant**: Somersille **Second**: Ting **Ayes**: Kliger, Kan, Marfatia, Po, Sharma, Somersille, Ting, Simone **Noes**: None **Abstain**: None **Absent**: Burn, Falwell **Recused**: None	***Adjourned to closed session at 7:04 pm***
12. AGENDA ITEM 17: RECONVENE OPEN SESSION/REPORT OUT	Open session reconvened at 7:27 pm. Agenda items 12-16 were addressed in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (11/01/2021), the Quality Council Minutes (11/03/2021) and the Medical Staff Credentialing and Privileges Report by unanimous vote by all committee members except for Dr. Burn and Ms. Falwell who was absent.	
13. AGENDA ITEM 18: CLOSING WRAP UP	Chair Kliger thanked the Committee for their service and dedication to the Hospital and community.	
14. AGENDA ITEM 19: ADJOURNMENT	**Motion**: To adjourn at 7:29 pm **Movant**: Simone **Second**: Po **Ayes**: Kliger, Kan, Marfatia, Po, Sharma, Somersille, Ting, Simone **Noes**: None **Abstain**: None **Absent**: Burn, Falwell **Recused**: None	***Adjourned at 7:29 pm***

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Julie Kliger, MPA, BSN
Chair, Quality Committee

Prepared by: Nicole Hartley, Executive Assistant II

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee
From: Stephanie Iljin, Manager of Administration
Date: February 7, 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, both the Hospital and District Boards have met once, excluding the study session held with this committee. 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 noted in this report.

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	December 8, 2021	- Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings - Minutes of the Open Session of the Hospital Board Meeting (11/08/21) - Minutes of the Closed Session of the Hospital Board Meeting (11/08/21) - Policy Revisions - FY21 Period 4 Financials - Intent to Reimburse: Resolution - Mountain View OBGYN Call Panel Renewal (Physician Contract) - Executive Compensation Committee Community Member Composition & new Community Member Appointments - Medical Staff Report Credentialing & Privileging Report - Board Effectiveness Report - Summary of Recommendations & Draft Action Plan - Chief Quality Officer Base Salary

Report on Board Actions
February 7, 2022

Board/Committee	Meeting Date	Actions (Approvals unless otherwise noted)
ECHD Board	January 25, 2022	- Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings - Minutes of the Open Session of the District Board Meeting (12/01/21) - Minutes of the Closed Session of the District Board Meeting (12/01/21) - ECHD FY22 YTD Financials - El Camino Healthcare District Board Health and Safety Code - FY22 El Camino Hospital Board Member Election Ad Hoc Committee Recommendation - FY22 El Camino Healthcare District Policy Bylaw Review Ad Hoc Committee Recommendations
Executive Compensation Committee	- N/A	
Compliance and Audit Committee	January 27, 2022	- Minutes of the Open Session of the CAC Meeting (11/18/2021) - Minutes of the Closed Session of the CAC Meeting (11/18/2021) - KPI Scorecard and Trends - Activity Log November 2021 - Activity Log December 2021 - Internal Audit Work Plan - Internal Audit Follow Up Table - Committee Pacing Plan
Finance Committee	January 31, 2022	- Minutes of the Open Session of the Finance Committee (11/22/2021) - Minutes of the Closed Session of the Finance Committee (11/22/2021) - FY 22 Period 5 Financials - FY 2022 PERIOD 6 FINANCIALS - MV Hospitalist Services Renewal - MV Interventional Radiology Panel

List of Attachments: None.

Suggested Committee Discussion Questions: None.

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

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

FY2022 Q1		
JULY 2021	**AUGUST 2, 2021**	**SEPTEMBER 7, 2021**
No Committee Meeting **Routine (Always) Consent Calendar Items:** ▪ **Approval of Minutes** ▪ **FY 22 Quality Dashboard** ▪ **Progress Against FY 2021 Committee Goals (Quarterly)** ▪ **FY22 Pacing Plan (Quarterly)** ▪ **Med Staff Quality Council Minutes (Closed Session)** ▪ **Hospital Update** **Additional Agenda Items:** 1. Health Care Equity 2. ~~Culture of Safety~~ (Oct 4) 3. Patient Perspective 4. Likely to Recommend 5. ~~Sepsis Mortality Goal/Target~~ (Dec 6) 6. Quality Metric Trends 7. OPPE 8. Systemness 9. Nurse Sensitive Indicators	Standing Agenda Items: 1. Report on Board Actions 2. Consent Calendar (PSI Report) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items 7. Q4 FY21 Quarterly Quality and Safety Review 8. Quarterly Board Dashboard Review 9. EL Camino Health Medical Network Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (ED Patient Satisfaction) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report QC Follow-Up Items Special Agenda items: 6. Annual Patient Safety Report 7. Pt. Experience (HCAHPS)
FY2022 Q2		
OCTOBER 4, 2021	**NOVEMBER 1, 2021**	**DECEMBER 6, 2021**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. FY 21 & FY 22 Quality Dashboard Results 8. Culture of Safety Survey Results	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (CDI Dashboard, Core Measures) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Safety Report for the Environment of Care 8. Q1 FY22 Quarterly Quality and Safety Review 9. FY 22 Quarterly Board Dashboard Review 10. EL Camino Health Medical Network Report 11. Medical Staff Office Audit Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda items: 7. Readmission Dashboard 8. PSI Report 9. Report on Medical Staff Peer Review Process 10. Sepsis Mortality Goal/Target Discussion

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

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

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

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Catherine Carson, MPA, BSN, CPHQ, Sr. Director Quality
Date: February 7, 2022
Subject: FY22 Enterprise Quality, Safety, and Experience Dashboard

Summary:

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

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

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

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

4. Assessment:

- **A.** Readmission Index for November @ 1.01 with 212 readmissions
- **B.** 6 SSEs for November 2021: 1- SSI, 3-HAPI, 1-retained foreign object (broken needle) and 1-delay in treatment
- **C.** Precursor Medication Safety Events: 20 errors that reached the patient but did not cause harm
- **D.** Mortality Index in December increased to 0.99 with 45 deaths
- **E.** HCAHPS Likelihood to Recommend for inpatient units was just above target at 80.0
- **F.** ED LTR improved to 9.5 and is above target
- **G.** ECH MD Likelihood to Recommend improved is below target at 74.7/
- **H.** One Surgical Site Infections in MV, a total hip arthroplasty
- **I.** Sepsis mortality Index for December increased to 1.07
- **J.** PC-01 was at zero for the both campuses
- **K.** PC-02, Cesarean Sections decreased across the enterprise
- **L.** Patient Throughput minutes increased, see annotation.

  See additional detailed comments in the annotation of the report

5. Other Reviews: None

6. Outcomes:

Suggested Committee Discussion Questions: None

FY22 Enterprise Quality, Safety, and Experience Dashboard
February 7, 2022

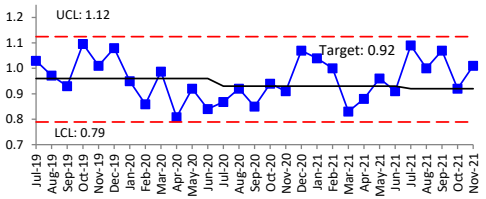
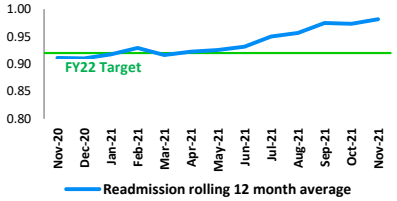
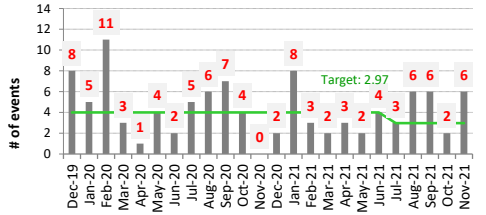
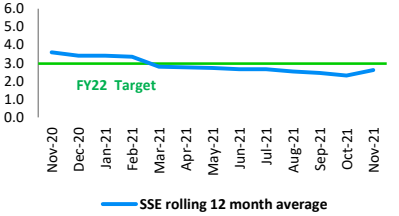
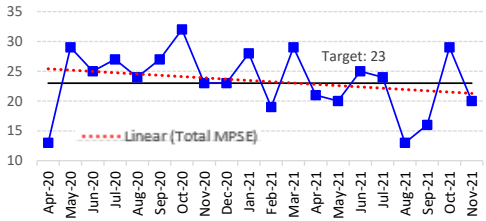
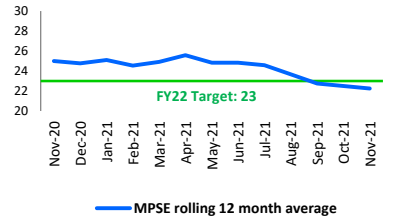
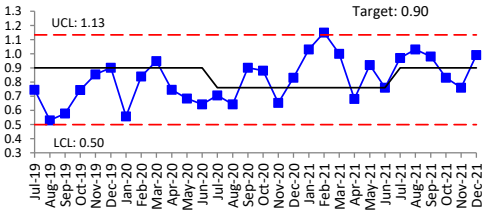
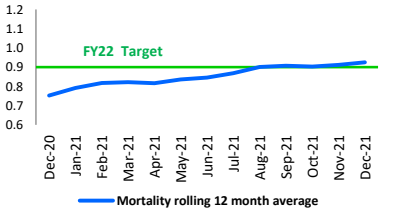
List of Attachments: FY 2022 Enterprise Quality, Safety, and Experience Dashboard, November & December data

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

December 2021 (unless otherwise specified)

Month to Board Quality Committee:
February, 2022

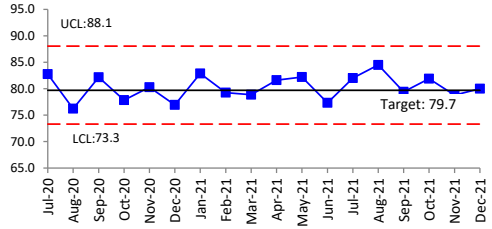
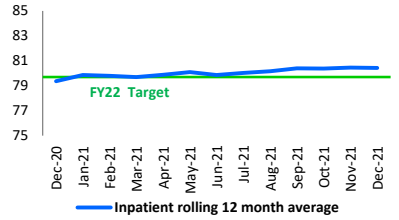
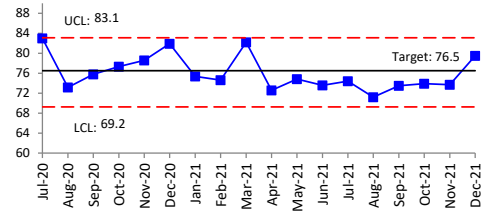
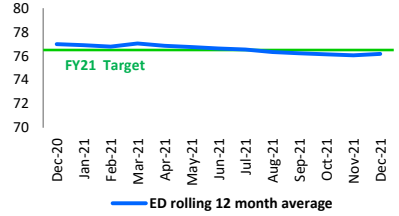
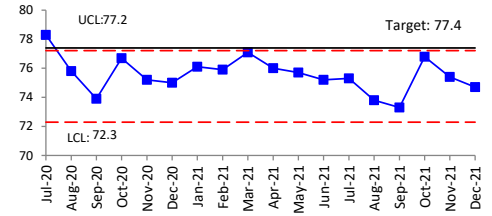
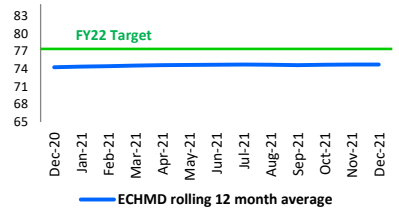
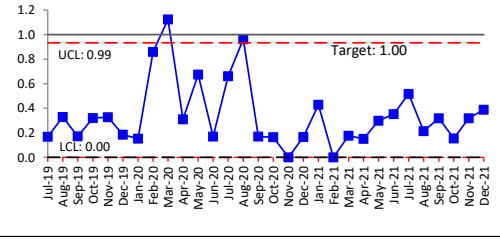
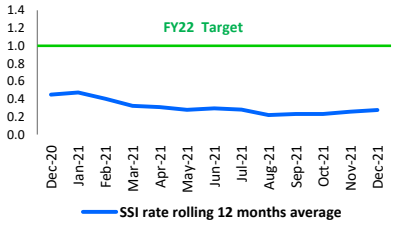
		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Month Average
		Latest month	FYTD				
1	***Organizational Goal** **Readmission Index (All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Standard Risk Calculation Mode*** ***Latest data month: November 2021*	1.01 (8.29%/8.21%)	1.01 (8.56%/8.44%)	0.93	0.92		
2	***Organizational Goal** **Serious Safety Event Rate (SSER) per month** # of events/ FYTD rolling 12 month per 10,000 Acute Adjusted Patient Days *Rate* ***Latest data month: November 2021*	6	2.62 (47/179649)	3.13 (Dec 2019 - Jun 2021)	2.97		
3	**Actual # of Medication Precursor Safety Events (MPSE) per month/** FYTD rolling 12 month average ***Latest data month: November 2021*	20	22.3/ mo. (12 month rolling average)	320 (25/month) *(April 2020 to April 2021)*	304 (23/month) *(5% reduction from baseline)*		
4	*** Strategic Goal** **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: December 2021*	0.99 (2.29%/2.31%)	0.92 (1.71%/1.85%)	0.86	0.90		

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

December 2021 (unless otherwise specified)

Month to Board Quality Committee:
February, 2022

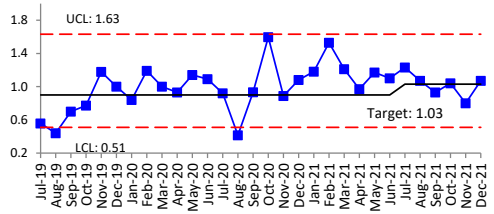
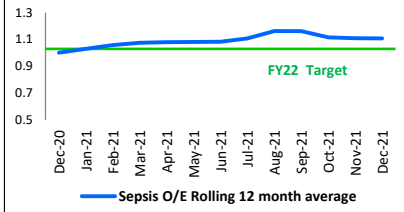
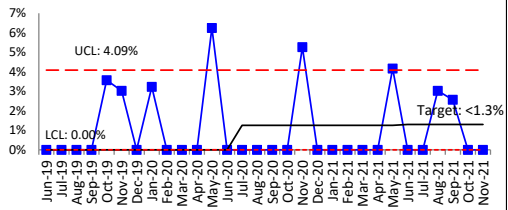
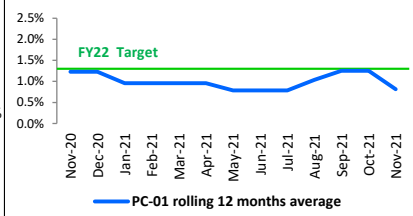
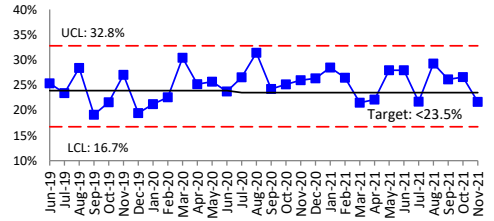
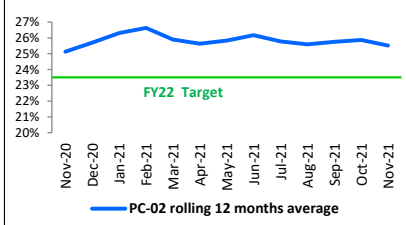
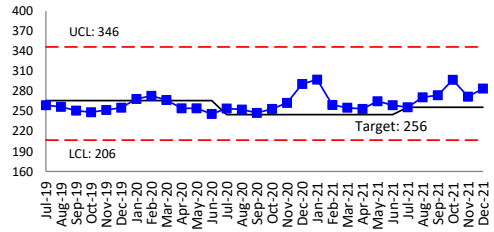
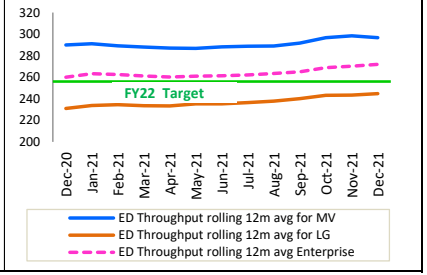
		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Month Average
		Latest month	FYTD				
5	*Organizational Goal **IP Units - HCAHPS Likelihood to Recommend -** *exec MBU,* **Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: December 2021*	80.0	87.0	79.6 (n=1983)	79.7		
6	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: December 2021*	79.5	74.5	76.1 (2347)	76.5		
7	* Organizational Goal **ECH MD : Likelihood to Recommend Care Provider** (SVMD only) **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Adjusted** *Latest data month: December 2021*	74.7	74.8	76.0 (n=15,330)	77.4		
8	**Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Latest data month: December 2021*	0.39 (1/258)	0.31 (10/3210)	0.30 (21/7016)	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

December 2021 (unless otherwise specified)

Month to Board Quality Committee:
February, 2022

		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Month Average
		Latest month	FYTD				
9	**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)* *Latest data month: December 2021*	1.07 (15.28%/14.29%)	1.03 (11.10%/10.83%)	1.08 (12.86%/11.87%)	1.03		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) **Latest data month: November 2021*	MV: 0.0% (0/17) LG: 0.0% (0/7) ENT: 0.0% (0/24)	MV: 0.7% (1/135) LG: 2.9% (1/35) ENT: 1.2% (2/170)	MV: 0.41% (1/244) LG: 1.32% (1/76) ENT: 0.63% (2/320)	1.3%		
11	**PC-02: Cesarean Birth** (lower is better) **Latest data month: November 2021*	MV: 23.5% (40/170) LG: 12.1% (4/33) ENT: 21.7% (44/203)	MV: 26.3% 209/795) LG: 19.9% (36/181) ENT: 25.1% (245/976)	MV: 27.58% (422/1530) LG: 20.69% (72/348) ENT: 26.30% (494/1878)	23.5%		
12	***Strategic Goal** **Patient Throughput- Median Time from Arrival to ED Departure** *(excludes psych patients, patients expired in the ED, Newborns, and transfer between sites)* *Latest data month: December 2021*	MV: 307 min LG: 261 min Ent: 284 min	MV: 302 min LG: 247 min Ent: 275 min	MV: 288 min LG: 239 min Ent: 264 min	MV: 263 min LG: 227 min Ent: 256 min		

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

Report updated: 1/26/22

NewYork-Presbyterian CXO Rick Evans: We are in a patient experience crisis

Rick Evans, Senior Vice President of Patient Services and Chief Experience Officer of NewYork-Presbyterian Hospital - Tuesday, December 7th, 2021 Print | Email

I've had the privilege of working to improve the patient experience in hospitals and healthcare settings for over 20 years. I've been part of teams that have successfully "moved the needle" year over year in challenging markets like Boston and New York.

Over this time, we saw the introduction of the national HCAHPS surveys that focused attention on the critical issue of patient experience in healthcare outcomes. We've seen a body of knowledge develop regarding patient experience, including deep understanding of patient experience data, development of evidence-based best practices and integration of patient experience as a key metric for any healthcare organization's success. We've continued to make progress in improving patient experience amid a rapidly changing healthcare environment. But I have never seen us in a situation like the one we are in at this moment.

As the pandemic continues, a related crisis in patient experience is unfolding before our eyes, and it is unlike anything we have seen before.

Patient ratings of the care they receive, which initially rose at the start of the pandemic, are plummeting across the country. A recent report on the "Impact of COVID-19 on Patient Experience" released by Press Ganey, an organization that administers surveys for hospitals across the nation, detailed precipitous drops in HCAHPS measures over the last year. Overall rating of hospital care dropped by 4 percentage points and patients' likelihood to recommend their hospital dropped by 4.5 percentage points. These declines come after years of these measures rising each year. For those who aren't familiar with how patient experience data moves, this is a huge drop. It represents a marked reversal of a longtime trend of improvement.

What is behind this drop? And what must we do to address it?

As I walk the halls of our hospitals at NewYork-Presbyterian, and as I speak with colleagues around the country — patient experience leaders, nursing leaders and others — there is consensus on what is happening. We are experiencing a troubling convergence of human and industry factors that have brought us to this moment.

First, the human factors are related to the toll that COVID-19 has taken and continues to take on all of us — both patients and healthcare staff. Early in the pandemic, patient ratings of their experience rose. We were in a crisis, and there was deep appreciation for healthcare workers. In New York, we saw that appreciation reflected in our ratings and also heard it every night at 7 p.m. when people would come to their windows to applaud and cheer. That was spring 2020. It's winter 2021, and the cheering has stopped. Everyone is exhausted. Tempers are short. The nation is divided on critical issues like mask-wearing and vaccinations. We have moved from a brief period of unity into an edgy and tense period. This plays out in all of our perceptions of healthcare, of our work and of each other. And, it is showing up in patient experience scores everywhere.

Then, there are industry factors, which exacerbate everything I described above. Emerging staff shortages that existed before the pandemic have dramatically worsened and are affecting every sector of our workforce — nurses, physician assistants, support services team members and more. We've all read about "the great resignation" and how many people in healthcare are rethinking their careers as we approach the end of the pandemic's second year. Supply chain shortages also make every shift just a little harder.

The pandemic's effects on hospital budgets further constrain our ability to address all of the above. Visitation restrictions remain and further strain interactions in our hospitals and at the bedside. Behavioral health-related

issues and conflict situations have also increased in many care settings.

This is a daunting list of challenges. All are interrelated and all erode the core elements of patient experience: our ability to connect with one another, communicate effectively and provide empathy when it is needed most. This is the patient experience equivalent of "long-haul COVID," and hospitals, patients, and staff are feeling it everywhere.

Here at NewYork-Presbyterian, we are trying to address these unprecedented challenges with a multi-faceted approach. We continue to maintain and build a robust array of programs to support our staff and nurture grit and teamwork. Like nearly every hospital in America, we have become more creative than ever in recruiting and retaining staff in a very competitive job market. We are reassessing our patient experience best practices and incorporating other teams from corporate and back-office areas to partner with our strained clinical front line to "spread the work and share the burden." And, we are accelerating efforts to leverage technology to enhance the patient experience where there are "pain points" in our patients' journeys through our system. We are trying to build on something we learned during this pandemic — that we can change quicker than we ever thought when we need to.

The arrival of the pandemic was devastating in so many ways — especially here in New York. But we rose to the challenge with teamwork and creativity. Responding to its latest effect, a corresponding patient experience crisis, will require the same dedicated effort. I believe if we commit ourselves to this work, we will not only be able to turn the tide toward recovery and further improvement, but also reshape what patient experience is and should be even when the pandemic is behind us.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP, RN, NEA-BC, DipACLM
Date: November 29, 2021
Subject: Patient Experience Feedback from Patient Letter

Purpose: To provide the committee with written patient feedback and subsequent follow up or changes as a result of the feedback.

Summary:

1. Situation: The feedback provided in these comments were from a discharge phone call. Each patient is called following discharge to ascertain their perception of the care experience at ECH and to assure questions are answered regarding discharge instructions.
2. Authority: To provide insight into one patient's experience while at El Camino Health.
3. Background: This patient was admitted through the Emergency Department for unscheduled surgery the following day.
4. Assessment: The patient indicates that while her hospital stay was good and the staff were wonderful. However, the patient expressed two different concerns. First, the patient indicated that she had hoped for the same nurse each shift and she was surprised the discharge process took as long as it did.
5. Other Reviews: None
6. Outcomes: In regard to the two concerns expressed by the patient, the staff use several workflows to assure continuity of information. When possible, nurse continuity is protected in patient assignments. In addition, the shift to shift handoff report is done systematically using a thorough and complete methodology which is a handoff tool in the E.H.R. Furthermore, a nurse to nurse handoff is done at the bedside in most locations at the change of shift. In addition, the nurse writes his/her name on the white board in the patient's room each shift for patient and family to visualize. The nurse's name also appears on the Get Well Network (TV network) for each shift she/he is assigned. Also, after the physician visits on the last day and writes a discharge order there is often more work the nurses need to do in order to assure the patient is ready for discharge including providing the discharge instructions the MD wrote during the discharge process and assuring the patient receives their medications before leaving if they desire from the OP pharmacy. We will communicate the expectations regarding discharge process to the patient/family as well as eliminate any wasted time requiring the patient to wait and insuring workflows that can be done before the day of discharge are built into our processes.
7. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. How do we assure that the nurses give thorough handoff and introduce each other?
2. How do prepare patients for the discharge process?

4A Mountain View --- Discharge phone call
Hospital stay – 11/30/21-12/06/21

I thought my hospital stay was great. The emergency room happened to be fairly empty. I got my surgery the next day. The nurses were wonderful. The doctor was great. I don't see how it could have been better. I did sort of wish that I had some of the same nurses over and over again but that's a minor detail. Apparently the way their schedule there's pretty much a different nurse every one every shift. But they left their names on the white board. They were all great so it was a wonderful experience. Thanks. The only bad part of it was the discharge took an hour and a half between when the doctor saw me then when we finally got discharged. That was fine, but I guess it would've been nice to get a heads up that it was going to take that much time. But otherwise it was wonderful.

El Camino Health

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: January 25, 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. 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. 8 MIPS metrics have been selected based on importance to patient care and impact on financial reimbursement as the Quality Measures. The results for FY 22 Q2 is a composite score of 3.5. The target composite score for FY22 is 3.6. ECHMN has added "soft stops" to some of the measures, updated the "tip sheets" for the staff and providers and we are retraining the staff. ECHMN has been working with the EPIC ICare team to implement "Heathy Planet" which will allow us to do population health management. We are also working on implementing the EPIC "Hedis Module" for our fully capitated health plans. We anticipate going live with both of these products in late Spring 2022.

The Net Promoter Score for ECHMN continues to be monitored. 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). The Net Promoter Score for December was 74.8,, which is below our target of 77.4; ECMHN is in the process of implementing Press Ganey as the patient satisfaction tool and July 2022, we will only be using Press Ganey.

ECHMN has also received Credentialing Delegation status from Anthem. We also passed the Valley Health Plan Credentialing Delegation audit with a score of 100%. The credentialing department has approved 7 initial appointments and 9 reappointments in the secondquarter of FY22.

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
Medical Network

Health System Quarterly Quality Report

Ute Burness, RN, Vice President, Quality & Payer Relations
Vince Manoogian, CMPE, Interim President, ECHMN

February 7, 2022

Measuring Quality in Ambulatory Care

- Ambulatory Care settings have many available metrics, ECHMN's monitors a Broad range of metrics which fall into three major categories: 1) A subset of >100 Ambulatory Care Quality Metrics Available, 2) The Merit-Based Incentive Payment System (MIPS) metrics, and 3) Patient Experience scores
- The subsequent slides will emphasize MIPS and ECHMN's metric subset

Subset of the Broad Range of Available Quality Metrics

Management monitors a subset of quality metrics (both publically reported, and/or established best practice metrics). The Quality Composite Score is a selection of 8 Quality Measures that are included in the publically reported measures from CMS. This composite, and associated detail are reported to the Quality Committee.

Merit-based Incentive Payment System (MIPS)

Part of the Quality Payment Program, rewarding clinicians for improving the quality of patient care and outcomes. Includes evaluation of 1) care quality, 2) improvement activities, 3) interoperability performance, and 4) Cost.

Final score determines whether clinicians receive a negative, neutral, or positive payment adjustment.

Quality Composite Metric Performance - FY22 Q2

- Improvements have been made within EPIC, staff and providers have been retrained, and outreach is being made to patients to close care gaps in order to improve quality of care.

Metric	FY21	FY22 Q1	FY22 Q2	FY22 Target
Composite Score (higher is better)	**3.4**	**3.5 ↑**	**3.5 ↔**	**3.6**
CMS 68- Documentation of Current Meds (higher is better)	3 (5th decile)	3 ↑ (5th decile)	3 ↔ (97%) (5th decile)	3 (5th decile)
CMS 69- Prevention and Screening Body Mass Index – Screening and Follow Up Plan (higher is better)	3 (6th decile)	3 ↑ (6th decile)	3 ↔ (58%) (6th decile)	3 (6th decile)
CMS 122- Diabetes: Hemoglobin A1C Poor Control (lower is better)	5 (10th decile)	5 ↔ (10th decile)	5 ↔ (24%) (10th decile)	5 (10th decile)
CMS 125- Breast Cancer Screening (higher is better)	3 (5th decile)	3 ↑ (6th decile)	3 ↔ (63%) (6th decile)	3 (6th decile)
CMS 130- Colorectal Cancer Screening (higher is better)	3 (5th decile)	3 ↑ (5th decile)	3 ↔ (47%) (6th decile)	3 (5th decile)
CMS 138- Tobacco Screening and Counseling (higher is better)	4 (8th decile)	4 ↔ (8th decile)	4 ↔ (97%) (8th decile)	4 (8th decile)
CMS 139- Fall Risk Screening (higher is better)	3 (6th decile)	3 ↑ (6th decile)	4 ↑ (91%) (7th decile)	4 (7th decile)
CMS 165- Controlling Blood Pressure (higher is better)	3 (6th decile)	4 ↑ (7th decile)	3 ↓ (59%) (6th decile)	4 (7h decile)

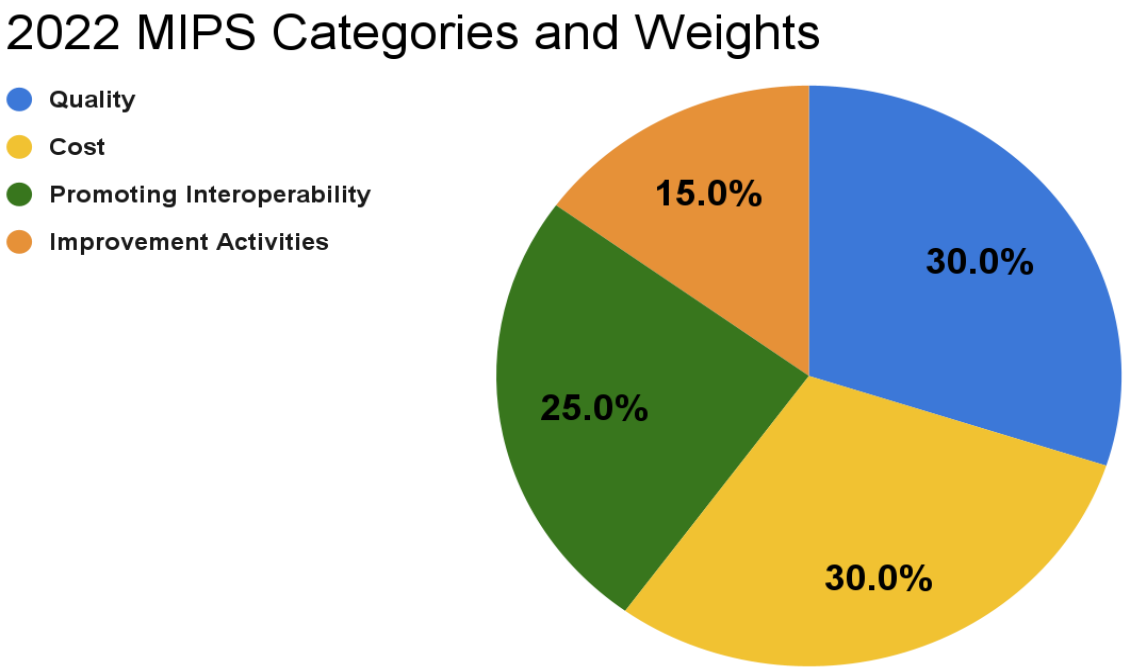
El Camino Health

Note: 10th is the highest decile

Merit-Based Incentive Payment System (MIPS)

- CMS granted “Covid wavier” to SVMD for 2021 data submission
- 2021 Year end data shows a projected score above 90%
- Data submission is due March 2022 for calendar year 2021
- The final score will be released by CMS in fall of 2022

Changes to MIPS for 2022



- Quality category weighting 30% (-10%)
- Cost category weighting 30% (+10%)
- Performance threshold is 75 points (+15 points)
- Exceptional performance threshold is 89 points (+4 points)
- Maximum payout remains the same with +/- 9% towards 2024 compensation
- Moving to MIPS Value Pathways (MVPs) starting with 2023 performance year, (voluntary until 2027)

2022 Quality Improvement Activities

- Dr. Jaideep Iyengar will replace Dr. Dan Morgan as the chairman of the quality committee
- Improvements to the Annual Wellness Visit process (*new templates, retraining of staff and providers, utilize mid levels)*
- Implementation of Medical Assistant Standardized Training and Assessment Program
- Epic Optimization
- HEDIS module for capitated plans
- Healthy Planet to provide real time information to the providers

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.
- **FY21 Performance:** 89.5 % (5th decile, 3 points)
- **FY 22 Target:** 91% (5th decile, 3 points)
- **2nd Qtr FY 22 Performance:** 97% (5th decile, 3 points)
- **1st Qtr FY 22 Performance:** 98% (6th decile, 3 points)
- **FY 22 Improvement Activities:**
  - *"Hard stop" has been implemented within EPIC*
  - *Clinical staff have been retrained and must address before closing the chart*

Points for each Decile		1	2	2	3	3	4	4	5	5
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
- **FY21 Performance:** 46.75% (6th decile, 3 points)
- **FY 22 Target:** 53% (6th decile, 3 points)
- **2nd Qtr FY 22 Performance:** 58% (6th decile, 3 points)
- **1st Qtr FY 22 Performance:** 51% (6th decile, 3 points)
- **FY 22 Activities:**
  - *"Hard Stop" implemented within EPIC*
  - *MA's retrained on the importance of taking height and weight and calculating BMI*
  - *Physician's retrained on the importance of documenting a follow –up plan at least annually*

Points for each Decile		1	2	2	3	3	4	4	5	5
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: Body Mass Index (BMI) Screening and Follow-Up Plan	47.6	<0.4	0.4 - 17.5	17.6 - 23.9	23 - 37.3	37.4 - 73.9	74 - 94.1	94.2 - 98.4	98.5 - 99.9	100

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.
- **FY21 Performance:** 30.75% (10th decile, 5 points)
- **FY 22 Target:** <29%(10th decile, 5 points)
- **2nd Qtr FY 22 Performance:** 24% (10th decile, 5 points)
- **1st Qtr FY 22 Performance:** 27% (10th decile, 5 points)
- **FY 22 Improvement Activities:**
  - *Diabetic patient list will be provided to each Physician*
  - *Providers have been retrained to work the Best Practice Alerts (BPA's) to make sure they are closing all care gaps*
  - *Physician will need to order HbA1c tests for any patient who has not had a test within this calendar year*
  - *Any patients with HbA1c over 9, bring the 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*

Points for each Decile		1	2	2	3	3	4	4	5	5
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
- **FY21 Performance:** 51.5% (5th decile, 3 points)
- **FY 22 Target:** 55% (6th decile,3 points)
- **2nd Qtr FY 22 Performance:** 63% (6th decile, 3 points)
- **1st Qtr FY 22 Performance:** 59% (6th decile, 3 points)
- **FY 22 Improvement Activities:**
  - *Quality Department will provide list of all patients that meet the criteria for 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*
  - *Reconciliation of outside mammograms*

Points for each Decile		1	2	2	3	3	4	4	5	5
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 Performance:** 44.5% (5th decile, 3 points)
- **FY 22 Target:** 45% (5th decile, 3 points)
- **2nd Qtr FY 22 Performance:** 47% (6th decile, 3 points)
- **1st Qtr FY 22 Performance:** 45% (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*

Points for each Decile		1	2	2	3	3	4	4	5	5
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	<0.1	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

- **FY21 Performance:** 98.25% (8th decile, 4 points)
- **FY 22 Target:** 94% (7th decile, 4 points)
- **2nd Qtr FY22 Performance:** 97% (7th decile, 4 points)
- **1st Qtr FY 22 Performance:** 98% (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 that patient received tobacco cessation intervention*

Points for each Decile		1	2	2	3	3	4	4	5	5
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

El Camino Health Medical Network

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 Performance:** 80.75% (6th decile, 3 points)
- **FY 22 Target:** 90.4% (7th decile, 4 points)
- **2nd Qtr FY 22 Performance:** 91% (7th decile, 4 points)
- **1st Qtr FY 22 Performance:** 88% (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*

Points for each Decile		1	2	2	3	3	4	4	5	5
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 165 – Controlling High Blood Pressure

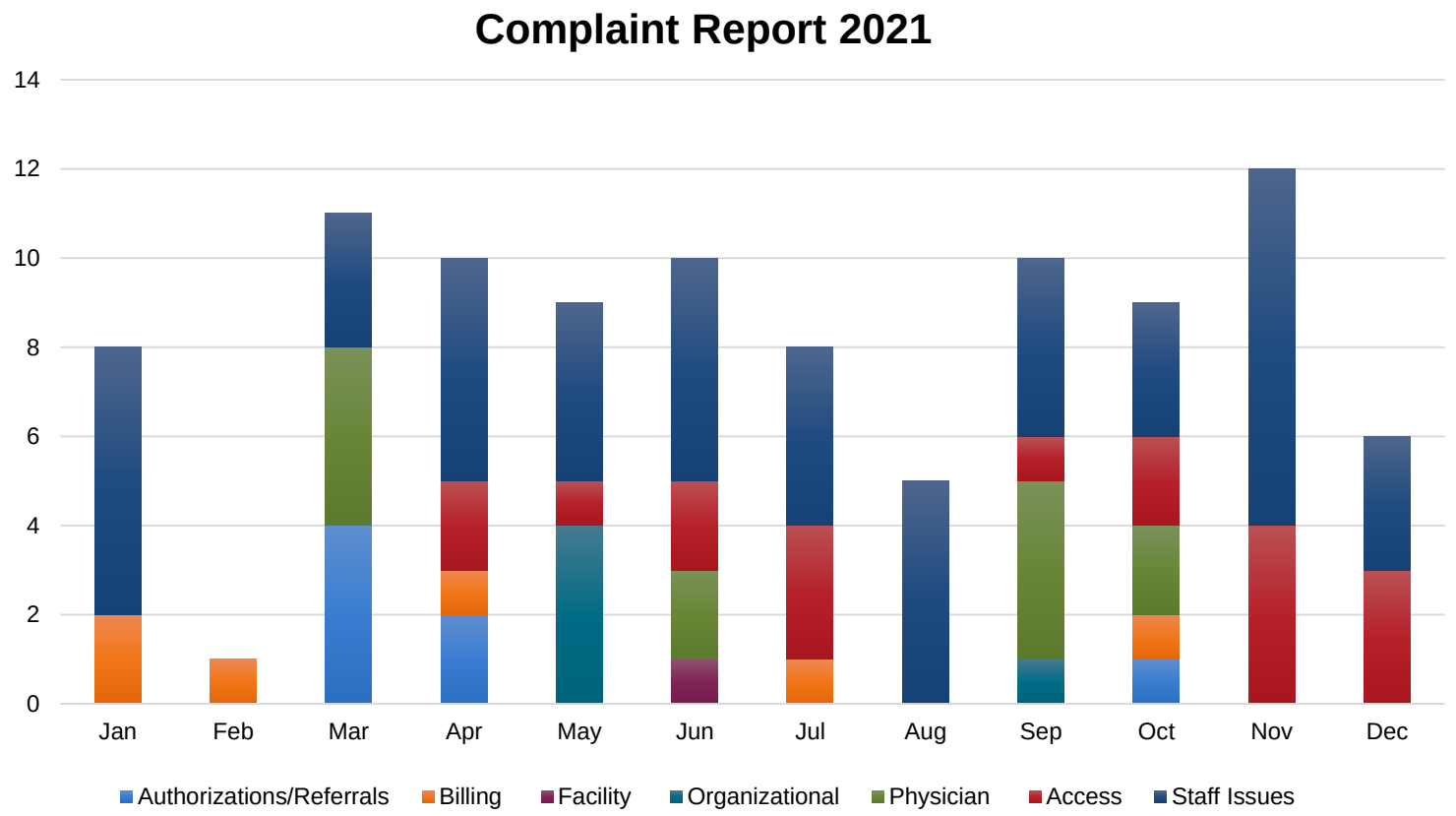
- **Description:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period
- **FY 21 Performance:** 57.75% (6th decile, 3 points)
- **FY 22 Target:** 60% (7th decile, 4 points)
- **2nd Qtr FY 22 Performance:** 59% (6th decile, 3 points)
- **1st Qtr FY 22 Performance:** 60% (7th decile, 4 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 Winter*
  - *For those patients whose Blood Pressure is too high, bring the patient in for a visit to discuss their treatment plan*

Points for each Decile		1	2	2	3	3	4	4	5	5
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

ECHMN Quality Report - Appendix

Complaints – Calendar Year- 2021

- Complaints are averaging about 7 per month, which is relatively low based on our total patient population.
- All complaints are based on the patients perception and all complaints are investigated.
- 50% of the complaints are about perceived staff issues.
- Management staff shares the feedback from the complaints with the appropriate staff.
- Complaints are shared with the appropriate management and departments, so that they are aware and if changes are necessary, changes can be made.



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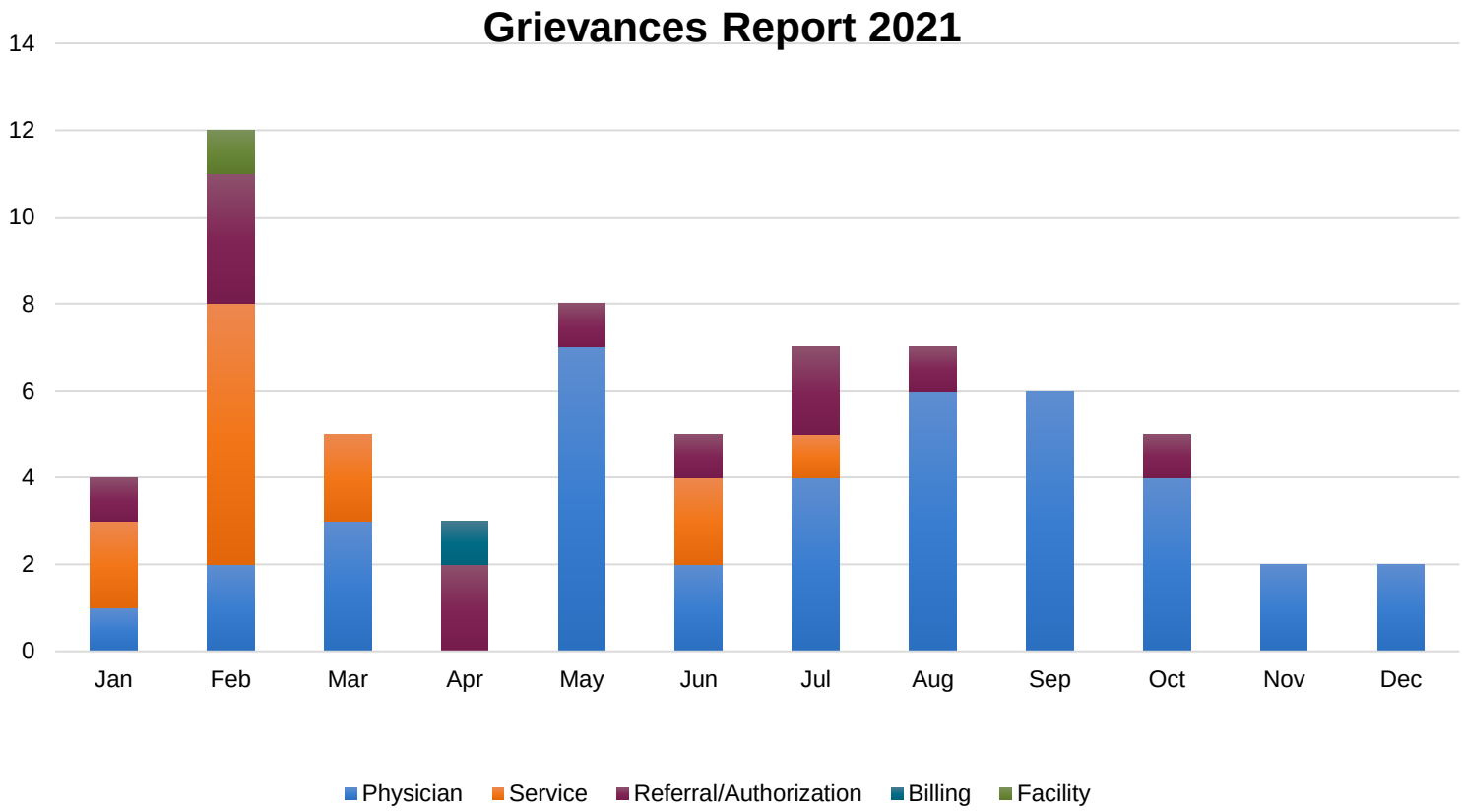
Grievances – Calendar Year 2021

- Grievances average about 5.5 a month, the last quarter saw a decrease in the number of grievances.
- Grievances are written complaints that member typically report to their health plan.
- Grievances are based on the patient's perception and all grievances are investigated.
- More than 50% of the grievances relate to perceived issues with the physician to include things like, access issues, delays in responding to messages and physician attitude and behavior.
- Grievances are shared with the providers, staff and appropriate departments, so that they are aware and if changes are needed, they can be implemented.



El Camino Health Medical Network

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
Holly Beeman MD, Chief Quality Officer
Date: December 7, 2022
Subject: Board Quality and Safety Dashboard

Purpose: To review the FY22 Q1 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 FYTD22 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. The previously noted spike in CAUTI instances has abated reflected in a reduction from 1.32 to .79 for Q2.

B. Timely:
- i. ED throughput continues to lag behind target. Contributing factors are increased volume and staffing challenges, increased acuity of the patients seeking care requiring more complex workups, and the need for continued COVID-19 testing. Adjunctive COVID test sites have been established to decant some of the ED patient demand. Hospitalist staffing has increased to try to meet this increased demand. The process improvement team continues to work on reducing the segments of door to ED doctor, ED doctor to admitting doctor, admitting doctor to admit orders, and admit orders to bed placement. More recently, 25 – 30 patients requiring admission have been housed in the ED for prolonged times because of lack of staffed hospital beds.
- ii. The three stroke measures are significantly below target:
  - **1.** Stroke: TTITT <30 min
  - *a.* *Cause:* For FY22, we shortened goal to 30 min. *Countermeasure*: In Nov, rolled-out TNK medication, requiring less prep. ECH's recent Q3 median time of 42 min was equal to GSH and faster than Stanford, Valley, & O'Connor.
  - b. *Cause:* Implementation of Teleneurology hit unexpected technical and training challenges. *Countermeasure:* In late December, enabled "auto answer" and desktop physician app for Teleneurology calls.

c. *Cause:* Radiology CT reading times slower than expectation. *Countermeasure*: Stroke Med. Dir. working with Radiology (and night service) to resolve.

2. Door to Device <90 min

a. *Cause:* TPA drip took 1+ hour before Cath Lab transport. *Countermeasure:* Implemented TNK instead (59 min savings); reinforced need to give in CT scan.

b. *Cause:* 7 of 9 cases were night; 3 Teleneurology errors. Night time ED-to-Cath-Lab transfers await on-call staff. *Countermeasure:* Anesthesiologists agreed to oversee patients; two weren't called by ED. Monthly workgroup underway; FY22 median is 97 minutes.

c. *Cause:* NeuroIR physician on-call response slower than expectation. Teleneurology missed 1 call to NeuroIR. *Countermeasure:* In May, adopted RAPID AI ASPECTS CT scan reading & created early activation algorithm. Engaged two NeuroIR physicians in program director roles.

C. Effective Care:

i. Readmission Index is elevated above the Premier Top Performers benchmark which is now 0.95. A multi-pronged approach has been implemented which includes the following teams: weekly readmission review which provides a Pareto analysis to focus the work, ERAS/Surgical complications, Cancer care, non-ventilator hospital acquired pneumonia, post-acute care and heart failure. This work is also supplemented by the newly initiated Cipher Discharge Phone Calls and the Care Companion.

ii. Sepsis Mortality Index has declined from 1.06 to 0.97 for Q2.

iii. PC-02 C/S rate and PC-01 early inductions have both trended downward.

D. Efficient Care: No issues

E. Equitable Care: No issues

F. Patient-Centered Care:

i. Trends are positive for Q2 but still below target for FY22.

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 FY22 Q1 and FYTD.

List of Attachments:

1. Q1 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: February 2021

Quarterly Board Quality Dashboard (STEEEP Dashboard) FY22 end of December (unless otherwise specified)

Quality Domain	Metric	Baseline	Target	Performance				
		FY 21	FY 22	FY22, Q1	FY22, Q2	FY22, Q3	FY22, Q4	FYTD22 Total
Safe Care	Serious Safety Events Rate (Rolling 12 month)	3.13	2.97	2.44	2.46			2.62
	Surgical Site Infections (SSI)	0.30	1.0 (SIR)	0.36	0.29			0.31
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	0.37	<= 0.75	1.32	0.79			1.07
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.53	<= 0.50	0.35	0.00			0.18
	Modified PSI-90 CMS HAC Reduction Program (composite)	0.919	0.90	0.846	0.873			0.807
Timely	HVI STEMI % 1st Medical Contact to Device Time w/I 90 minutes	100%	100%	100% (13/13)	NA (available only up to Q1)			100%
	Patient Throughput - Median Time Arrival to ED Departure	264 min	256 min	267 min	284 min			275 min
	Stroke: TTITT (time to intravenous thrombolytic therapy) <= 30 min	57.5% (14/23)	50%	25% (1/4)	10% (1/10)			14.3%
	Stroke: Door-to-Groin <= 75 minutes	16.7% (3/18)	50%	50% (1/2)	14.3% (1/7)			22.2%
	Stroke: Door-to-Groin <= 90 minutes	50% (9/18)	NA	50% (1/2)	28.6% (2/7)			33.3%
Effective	Risk Adjusted Readmissions Index	0.93	0.92	1.07	*0.96			1.01
	Risk Adjusted Mortality Index	0.86	0.90	0.99	0.87			0.92
	Sepsis Mortality Index	1.08	1.03	1.06	0.97			1.03
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	ENT: 0.63%	1.3%	1.8%	*0%			1.2%
	PC-02 NTSV C-Section	ENT: 26.3%	23.5%	25.8%	*24.1%			25.1%
	ECHMN: CMS 165 Controlling High Blood Pressure	59.0%	>= 59%	60.0%	59.0%			59.0%
	ECHMN: CMS 122 Diabetes Hemoglobin A1c Poor Control	30.0%	<= 30	24.0%	26.0%			25.0%
Efficient	Arithmetic Observed LOS/ Geometric Expected LOS	1.29	1.30	1.35	1.33			1.34
	MSPB-1 Medicare Spending per Beneficiary (CMS)	0.99 (CY 19)	<=1	0.99	1.0 (CA: 1.0, NA: 0.99)			0.99
Equitable	Hospital Charity Care Support	$19.7 mil	NA	7.2 mil	11.5k			18.7 mil
	Clinic Charity Care Support	$14.9k	NA	7.5k	3.0k			10.5k
	Language Line Unmet Requests	0.72%	<1%	0.62%	0.36%			0.50%
	Length of Stay Disparity (Top 3 races) 40% patients did not report their race	Black: 4.0	NA	4.3	4.03			4.15
		White: 3.89		3.77	3.88			3.83
		Asian: 3.57		3.59	3.67			3.63
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	79.6	79.7	82.0	80.2			81.2
	ED - Likelihood to Recommend (PG)	76.1	76.5	73.1	75.7			74.5
	ECHMN - Likelihood to Recommend Care Provider (NPS)	76.0	77.4	74.1	75.6			74.8
	MCH - HCAHPS Likelihood to Recommend	81.8	82.0	79.4	80.5			80.2
	OAS - HCAHPS Likelihood to Recommend	85.7	86.1	85.5	87.6			86.5

Report updated 1/25/2022

*data available up to November only

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