El Camino Health

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

Monday, March 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: 967 4702 7374#. 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 (02/07/2022) ***Information*** b. Report on Board Actions c. FY 22 Pacing Plan d. FY 22 Enterprise Quality Dashboard e. QC Follow-Up Items			
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 – 6:03**
6.	**PATIENT & FAMILY VOICES IN QUALITY COMMITTEE MEETINGS**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:03 – 6:18**
7.	**ENTERPRISE QUALITY TARGETS**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:18 - 6:38**
8.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**discussion 6:38 - 6:41**
9.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 6:41 – 6:42**
10.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 6:42 - 6:43**

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
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 (02/07/2022) b. Quality Council Minutes (02/02/2022)	Julie Kliger, Quality Committee Chair		**motion required 6:43 – 6:44**
12.	**CHAIR'S REPORT**	Julie Kliger, Quality Committee Chair		**information 6:44 – 6:49**
13.	*Health and Safety Code Section 32155* **CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer		**motion required 6:49 - 7:04**
14.	*Health and Safety Code Section 32155* **SERIOUS SAFETY/RED ALERT EVENT**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 7:04 – 7:09**
15.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:09 - 7:10**
16.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		**information 7:10– 7:11**
17.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 7:11 – 7:14**
18.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:14 – 7:15 pm**

Next Meeting: April 4, 2022, May 2, 2022, June 6, 2022

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, February 7, 2022
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

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

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 and Dr. Kan were not present during roll call. Dr. Burn joined at 5:34 pm. All other members were present at roll call and participated in-person or telephonically. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair 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	Chair Miller asked to approve the Consent Calendar. Dr. Sharma requested to pull item 3d – FY22 Enterprise Quality Dashboard for discussion. Chair Miller called for discussion regarding agenda item 3d. Dr. Sharma requested to have the definitions added back onto the Dashboard. Dr. Sharma also asked for additional information around ED Throughput and how the focus initiatives impacted the Throughput numbers. Cheryl Reinking, CNO shared that continuous efforts are being made to improve ED Throughput. Based on current analysis, the hospital is working on ensuring beds are available for patients who are admitted through the ED which means admitting patients as quickly as possible. To make this possible, processes need to improve. The process focal points are working with the Capacity Management Center to ensure discharged modules are implemented and new rounds with hospitalists to help us identify barriers earlier. In addition, 10 flex beds are available to help accommodate ED Patients.	***Consent Calendar approved***

	Motion: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (12/06/2021); For information: (b) Report on Board Actions, (c) FY 22 Pacing Plan, (d) FY 22 Enterprise Quality Dashboard (e) Article of Interest **Movant**: Burn **Second**: Sharma **Ayes**: Kliger, Burn, Marfatia, Po, Sharma, Somersille, Ting, Falwell, Simon **Noes**: None **Abstain**: None **Absent**: Kan **Recused**: None	
4. CHAIR'S REPORT	Chair Kliger introduced and welcomed our new Chief Quality Officer Dr. Holly Beeman to the Committee. Dr. Holly Beeman addressed the Committee as the new Executive Sponsor for the Committee. Dan Woods, CEO echoed the welcome to Dr. Holly Beeman.	
5. PATIENT STORY	Cheryl Reinking, CNO presented a patient story regarding feedback received from a discharge phone call. The patient expressed that while her stay and the staff were good, she had two concerns about her experience. The two concerns were that she had hoped for the same nurse each shift and she felt that the discharge process took a long time. For the 1st concern, the likeliness of the same nurse attending the patient is low due to 70% of nurses working part-time. To ensure a smooth transition, a bedside handoff is completed to introduce the nurse and ensure continuity of information. For the 2nd concern, the discharge process can take time due to the additional work needed after the Doctor has discharged the patient. The nurse will provide discharge instructions and ensure that the patient receives their medication before leaving. Improving our communication to the patient regarding expectations regarding the next steps after discharge is received is key to resolving this gap.	
6. EL CAMINO HEALTH MEDICAL NETWORK REPORT	Vince Manoogian, Interim President, ECHMN, and Ute Burness, VP of Quality and Payer Relations presented on the Health System Quarterly Quality Report and reviewed the following: • Measuring Quality in Ambulatory Care • Quality Composite Metric Performance – FY 22 Q2 • Merit-Based Incentive Payment Systems (MIPS) • Changes to MIPS for 2022 • 2022 Quality Improvement Activities • CMS 138 – Preventative Care and Screening Tobacco Use A discussion ensued with the Committee.	

7. QUARTERLY BOARD QUALITY DASHBOARD REVIEW	Dr. Holly Beeman, CQO presented on the Quarterly Board Quality Dashboard and highlighted the following: • Infection Prevention: Partnering with physicians and staff to provide re-education on CAUTI prevention • Stroke Metrics - Door to Needle: During peak COVID when family/visitors were not allowed in ED, it was difficult for the care team to identify if the patient is altered from their baseline, and, **when** the change in condition occurred. If the patient is coming from SNF without family present, obtaining this information in a timely way proved challenging. Because IV thrombolytic therapy must be administered within 4.5 hours of the onset of stroke or administering thrombolytic therapy beyond that window causes GREAT harm, there needs to be a high degree of confidence around the timing of the onset of the symptoms. • Stroke Metrics - Door to Groin: Denominator 7 patients in Q2. Time decreased from 90 to 75 minutes. Current performance is similar to performance in FY21. • Readmission Index: Q2 improved from Q1 but is still off target. Current at 0.96 and target is 0.92. This rate is predominately impacted by 4 groups: Heart Failure, 1-day readmissions, Alcohol withdrawal, and Post-partum hypertension. A discussion ensued with the Committee.	
8. PUBLIC COMMUNICATIONS	There were no comments from the public.	
9. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 6:38 pm. **Movant**: Burn **Second**: Po **Ayes**: Kliger, Burn, Marfatia, Po, Sharma, Somersille, Ting, Falwell, Simon **Noes**: None **Abstain**: None **Absent**: Kan **Recused**: None	***Adjourned to closed session at 6:38 pm***
10. AGENDA ITEM 16: RECONVENE OPEN SESSION/REPORT OUT	Open session reconvened at 7:35 pm. Agenda items 10-16 were addressed in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (12/06/2021), the Quality Council Minutes (12/01/2021), the Quality Council Minutes (01/05/2022) and the Medical Staff Credentialing and Privileges Report by unanimous vote by all committee members except for Dr. Kan who was absent.	
11. AGENDA ITEM 17: CLOSING WRAP UP	No additional comments	

12. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 7:36 pm **Movant**: Burn **Second**: Simon **Ayes**: Kliger, Burn, Marfatia, Po, Sharma, Somersille, Ting, Falwell, Simon **Noes**: None **Abstain**: None **Absent**: Kan **Recused**: None	***Adjourned at 7:36 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: March 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, the Hospital Board has met twice and the District Board has not met. 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	February 9, 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 Hospital Board Study Session(12/01/21) - Minutes of the Closed Session of the Hospital Board Study Session(12/01/21) - Minutes of the Open Session of the Hospital Board Meeting (12/08/21) - Minutes of the Closed Session of the Hospital Board Meeting (12/08/21) - Plans, Policies, and Scope of Services - FY21 Period 6 Financials - Mountain View ED & Inpatient On-Call Interventional Radiology Panel Agreement Renewal - Enterprise Radiology Professional Services Agreement Renewal - Medical Staff Report - Board Member Benefits Report - Credentialing & Privileging Report - ByLaws - Investment Advisory Firm RFP

Report on Board Actions
March 7, 2022

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
	February 23, 2022 (Retreat)	- N/A
ECHD Board	- N/A	
Executive Compensation Committee	- N/A	
Compliance and Audit Committee	- N/A	
Finance Committee	- N/A	

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: Holly Beeman, MD, MBA, Chief Quality Officer
Date: March 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 2022 metrics monthly with trends over time and compared to the actual results from FY2021 and the FY 2022 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. This Committee selected these twelve (12) metrics for monthly review as they reflect the Hospital's FY 2022 Quality, Efficiency and Service Goals.

4. Assessment:

- **A.** We had 101 readmissions in November and December. The Observed over expected index decreased (good) to .93 in December The index was 1.0 in November. Previously reported for February; awaiting updates from Risk Management.
- **B.** There were 6 SSEs for November 2021: 1- SSI, 3-HAPI, 1-retained foreign object (broken needle) and 1-delay in treatment. We are currently below target (good) for the year. Awaiting Dec results from Risk Management.
- **C.** Previously reported for February; awaiting updates from Risk Management. Precursor Medication Safety Events: 20 errors that reached the patient but did not cause harm
- **D.** Mortality Index for January decreased to 0.80 with 46 deaths. The most common causes are Sepsis (n=20), Cancer (n=6), COVID (n=4) and Cardiac n=4).
- **E.** HCAHPS Likelihood to Recommend for inpatient units is 76.2 which is 3.5% below target
- **F.** ED LTR remains over target @ 79.1; ED LTR improved to **7**9.5 and is above target
- **G.** ECH MD Likelihood to Recommend remains below target but continues to improve @ 75.2
- **H.** Preliminary numbers zero Surgical Site Infections.
- **I.** Sepsis mortality Index for January is 0.93, well below target of 1.03. Note: FYTD 17 (15%) of Sepsis deaths are COVID patients
- **J.** PC-01 was at zero for the both campuses
- **K.** PC-02, Cesarean Sections decreased across the enterprise

L. ED wait times increased again for January (not good). Two causes are increase volume and severity of patients, and, inadequate bed capacity on inpatient units. The patient throughput value stream for FY22 continues to focus on stabilizing the capacity management center (CMC). We hired a Capacity Management Supervisor for the PM shift and she started on Feb 7th. The hospitalist teams are also focused on early discharges for patients discharged to home under the direction of Dr Mallur.

5. Other Reviews: None

6. Outcomes:

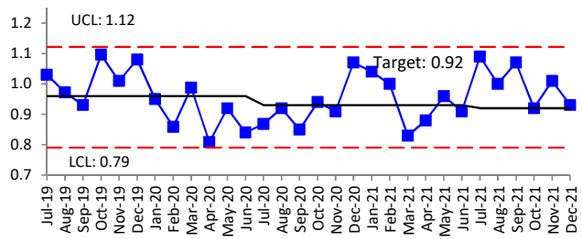
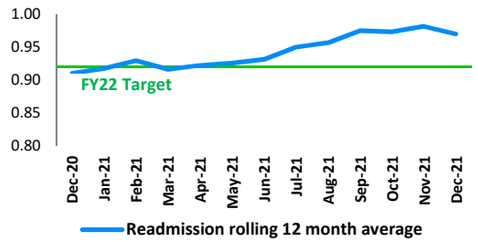
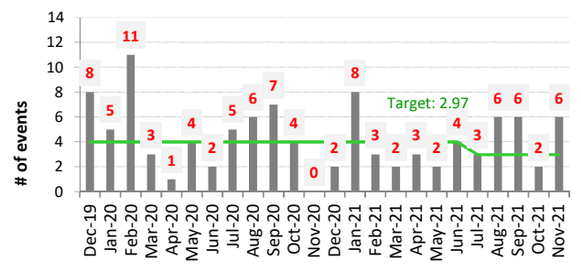
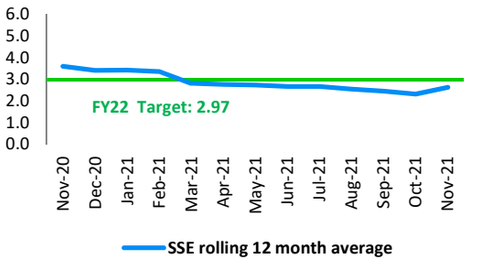
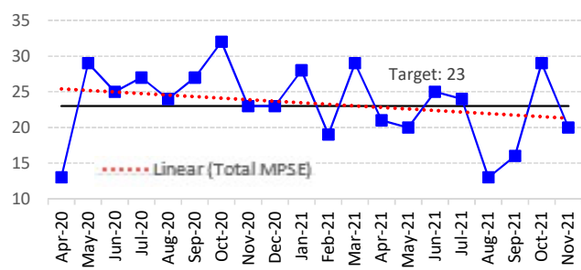
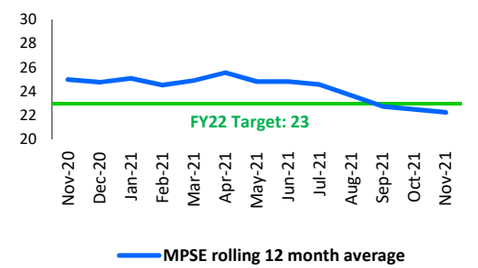
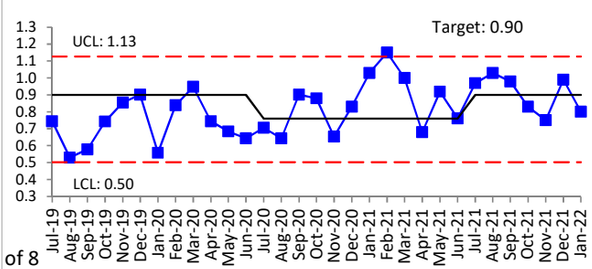
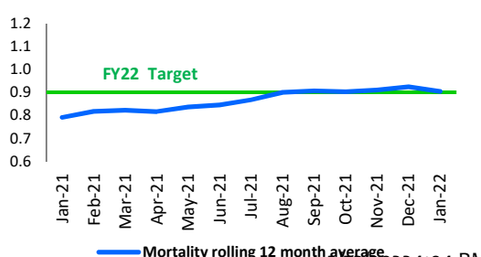
Suggested Committee Discussion Questions: None

List of Attachments: FY 2022 Enterprise Quality, Safety, and Experience Dashboard, November – January data

El Camino Health

January 2022 (unless otherwise specified)

Month to Board Quality Committee:
March, 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: December 2021*	0.93 (8.02%/8.62%)	1.00 (8.47%/8.47%)	0.93	0.92		
2	***Organizational Goal** **Serious Safety Event Rate (SSER)** # 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: January 2022*	0.80 (2.45%/3.06%)	0.90 (1.81%/2.02%)	0.86	0.90		

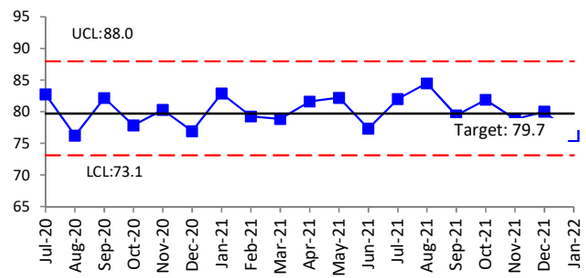
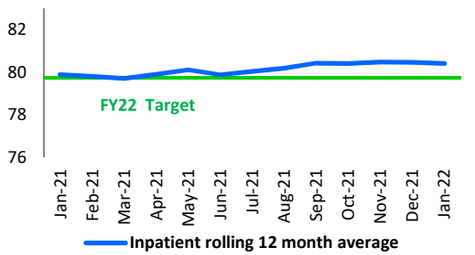
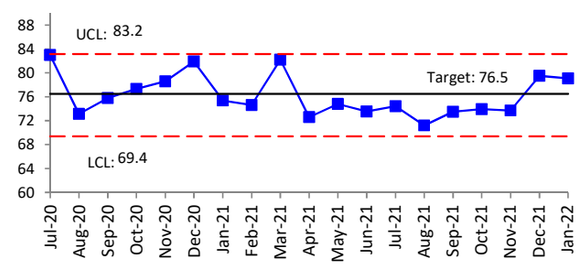
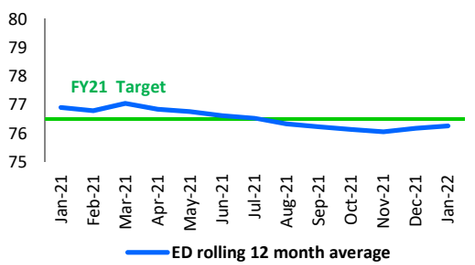
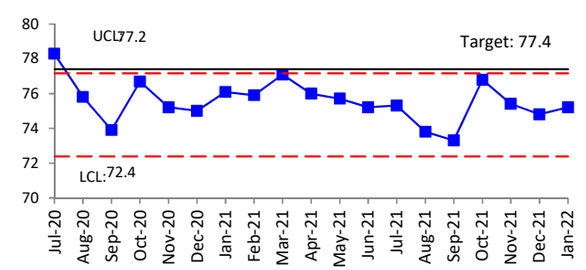
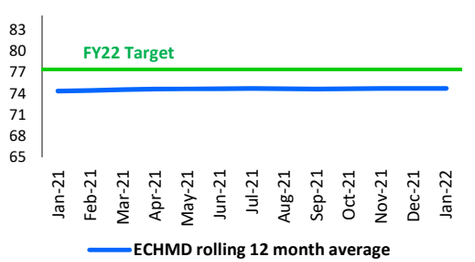
Definitions and Additional Information

Measure Name	Comments	Definition Owner	Definition	Source
1. Readmission Index - All Patient All Cause Readmit (Observed/Expected)		Holly Beeman	Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted). Includes Inpatient Units *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
2. Serious Safety Event Rate (SSER)		Sheetal Shah	Definition of serious safety event is an event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. Inclusion is events determined to be serious safety events per Safety Event Classification team *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**HPI Systems**
3. Actual # of Medication Precursor Safety Events per month		Deep Mattapally	All medication events classified as precursor safety events by Safety Event Classification Team EPSI report used for Patient days and # of events provided by Deep M. *Target data received from Sheetal on 8/12/21 via email - 5% reduction from baseline*	iSafe Reports / EPSI Report / Safety Event Classification
4. Mortality Index (Observed/Expected)		Holly Beeman	Updated 7/1/19 (JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	Premier Quality Advisor

El Camino Health

January 2022 (unless otherwise specified)

Month to Board Quality Committee:
March, 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: January 2022*	76.2	80.3	79.6 (n=1983)	79.7		
6	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: January 2022*	79.1	75.3	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: January 2022*	75.2	74.9	76.0 (n=15,330)	77.4		

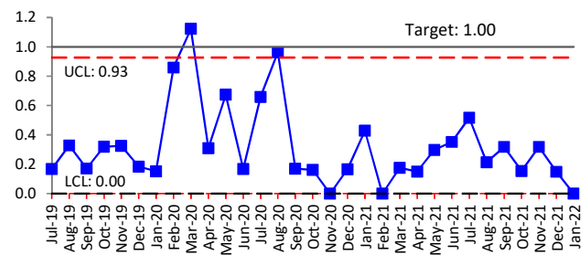
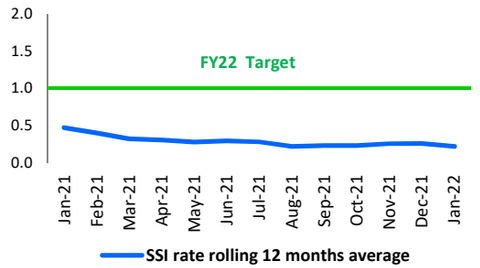
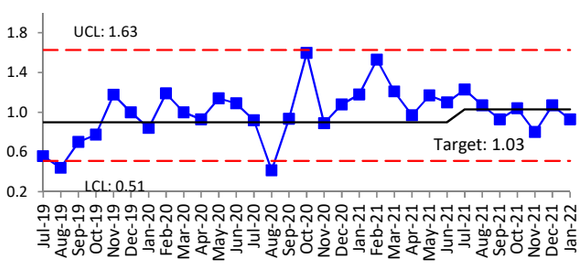
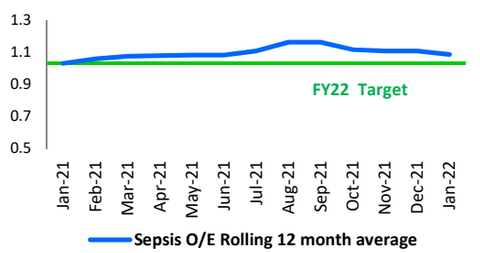
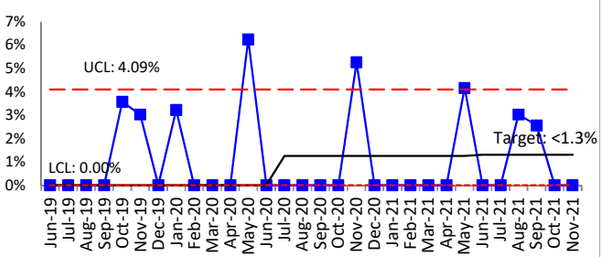
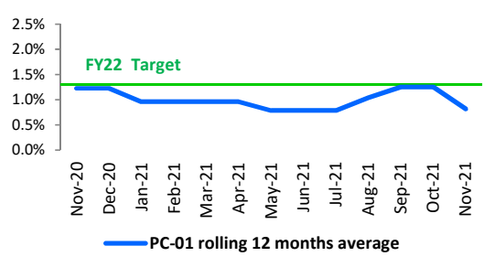
Definitions and Additional Information

Measure Name	Comments	Definition Owner	Definition	Source
5. Inpatient Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.' % , Adjusted		Christine Cunningham	IP Units only, Excludes MCU. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Adjusted' *New FY22 Target received from Christine 10/18/2. Criteria changed to Adjusted score for Board reports/ external reports* *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey**
6. ED - Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.'%, Adjusted		Christine Cunningham	ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted' *New FY22 Target received from Christine 10/18/2. Criteria changed to Adjusted score for Board reports/ external reports* *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey**
7. ECH MD/ ECHMN (El Camino Health Medical Network) - Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted		Christine Cunningham	ECHMD – does not have HCAHPS – we use only one data point that is NPS (net promotor score), which is a likelihood to recommend care provider (SVMD only). Switching Vendor NRC to PressGaney in January 2022. Data run criteria, 'Top Box, Received Date, and Adjusted' *New FY22 Target received from Christine 10/18/2. Criteria changed to Adjusted score for Board reports/ external reports* *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**NRC**

El Camino Health

January 2022 (unless otherwise specified)

Month to Board Quality Committee:
March, 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				
8	**Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Latest data month: January 2022*	0.00 (0/212)	0.26 (10/3836)	0.30 (21/7016)	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		
9	**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)* *Latest data month: January 2022*	0.93 (17.24%/18.56%)	1.00 (12.07%/12.05%)	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%		

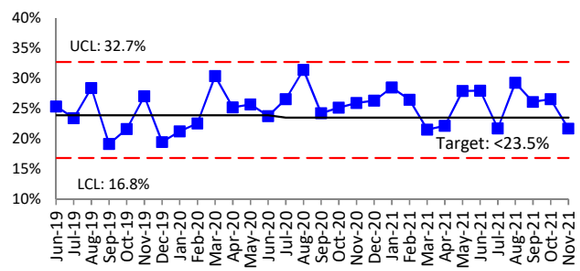
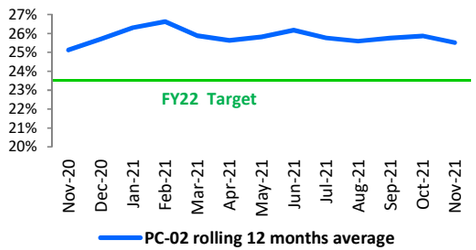
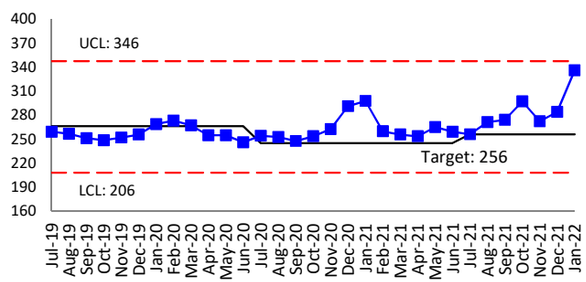
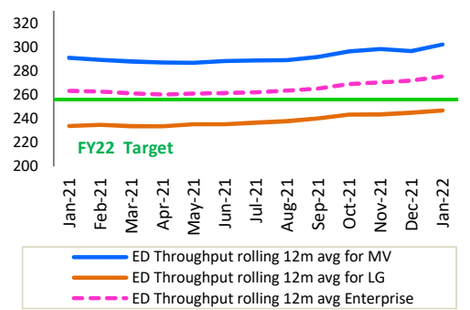
Definitions and Additional Information

Measure Name	Comments	Definition Owner	Definition	Source
8. Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100		Holly Beeman/Catherine Nalesnik	**Inclusion:** 1) Based on NHSN defined criteria 2) All surgical cases that are categorized as "clean wound class" and "clean-contaminated wound class" are considered for investigation 3) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. **Exclusion:** 1) All surgical cases that have a wound class of "contaminated" and "dirty" are excluded. 2) All surgical case that are considered an infection PATOS (present at time of surgery). 3) All "superficial" SSIs are not reportable. FY22 Target, Ent = same as last year =< 1.0 (SIR) *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average .* *Lower Control Limit is not visible if it is less than or equal to zero .*	**CDC NHSN database - Inf. Control**
9. Sepsis Mortality Index, based on ICD-10 codes *(Observed over Expected)*		Jessica Harkey, Holly Beeman	Effective 01/24/20: The original definition for Sepsis (used in this dashboard) 1) evaluated only the Principal diagnosis, & 2) excluded cases assigned the patient type of Rehabilitation or Other (Hospice). The definition has now been aligned with CMS' to 1) evaluate both principal AND secondary diagnoses, & 2) excludes: patients < 18 years, LOS => 120 days, or Transfers from Another Acute Hospital, as well as the Patient Type of Rehabilitation or Other (Hospice). This was reviewed with & approved by Jessica Harkey, Sepsis Manager and Catherine Carson Sr. Director Quality. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
10. PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed		TJC	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed FY22 Target, Ent. = 1.3% (same as FY21) *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**

El Camino Health

January 2022 (unless otherwise specified)

Month to Board Quality Committee:
March, 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				
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: January 2022*	MV: 391 min LG: 281 min Ent: 336 min	MV: 311 min LG: 253 min Ent: 282 min	MV: 288 min LG: 239 min Ent: 264 min	MV: 263 min LG: 227 min Ent: 256 min		

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

** Readmission data are available up to December

Report updated: 2/21/2022

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Definition	Source
11. PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth		TJC	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation FY22 Target, Ent. = 23.5% (same as FY21) *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
12. Patient Throughput-Median Time from Arrival to ED Departure (excludes psychiatric patients, patients expired in the ED and Newborns, excludes transfer between sites		Cheryl Reinking, Melinda Hrynewycz	This measure definition is changed in Feb. 2020 regarding the end point. New definition is "Arrival to ED Departure", and is the same as CMS ED Measure (ED 1b) ED Arrival to ED Departure for Admitted pts. Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, newborns and transfer between sites FY22 Target, Ent. = 256 mins (same as FY21) Arrival: Patient Arrived in ED ED Departure: Departed ED *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**iCare Report: ED Admit Measurement Summary**

As of: 03/07/22

Quality Committee Follow-Up Items

Date Requested	Committee Member Name	Item Requested	Completion Date
2/7/2022	Krutica Sharma	Please add the definitions back onto the Enterprise Dashboard	3/7/2022
2/7/2022	Krutica Sharma	Please include the Red Flags for the Medical Staff Credentialing Privileges Report	3/7/2022

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: Feb. 25, 2022
Subject: Patient Experience Feedback

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 healthgrade review regarding Dr. Dormandy one of our SVMD oncologists.
2. Authority: To provide insight into one patient's experience while at El Camino Health Cancer Center.
3. Background: This patient is a cancer patient whom Dr. Dormady is treating that was impressed with the personal connection and personalized care that he received from his physician.
4. Assessment: The patient indicates that his interaction with Dr. Dormady was obviously meaningful. He noticed all the things Dr. Dormady did to make sure he understood all his treatment options and expressed he treated him like a human with dignity and respect.
5. Other Reviews: None
6. Outcomes: This positive review is shared with the board to indicate that the We Care standards are being exemplified by providers in the organization so much so that a patient took the time to comment in Health Grades.
7. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. How do other providers learn from Dr. Dormady?

2. How do provide this feedback to Dr. Dormady and other care givers?

Healthgrades review, rating Dr. Dormady with 5 stars.

Dr. Dormady is an amazing hematologist/oncologist that explained my condition in terms that I could understand. He took his time in making me feel not only as a patient but related to me as a real person and called me by my first name (3) times during my visit. At our visit, Dr. Dormady said “it’s my job for a patient to walk out of my office knowing that I was able to explain their disease in terms a patient can understand.” He hugged me at the end of my visit and I walked out of his office sharing with my family all providers need to learn from Dr. Dormady that patient experience is not about the revenue but about treating patients with dignity, respect, and educating patients with their treatment options. I highly recommend him to all patients and to seek care at El Camino Health!

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board of Directors, El Camino Health
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: March 7, 2022
Subject: Enterprise Quality Targets

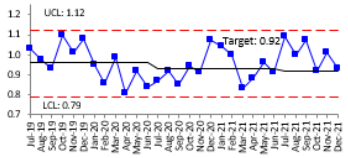
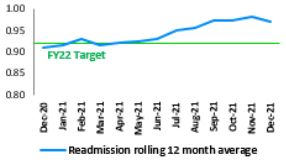
Purpose:

To discuss three measures from the Enterprise Quality Dashboard

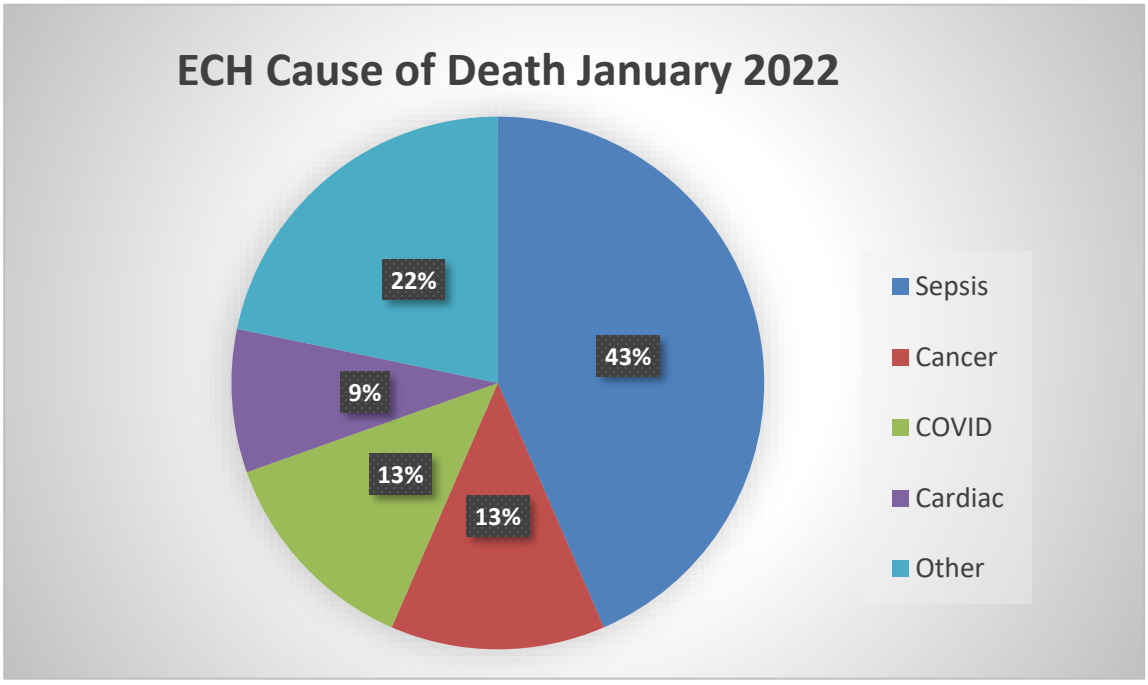
Summary:

Dr. Beeman will discuss three of the 12 measures tracked on the monthly Enterprise Quality Dashboard. This report differs from the STEEP report as it provides more detail including control charts, showing month-to-month performance and a 12-month rolling average. The three measures explored in more detail will be: Readmission Index, Mortality Index, and Surgical Site Infections.

1. Readmission Index (Observed/Expected)
    a. Definition
        Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, Care Science Risk Adjusted).
        Includes Inpatient Units. For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.
        LCL is set to '0' if value is less than or equal to zero.
    b. Across the country, hospitals are experiencing increased readmissions. A year from now, we will have better clarity with peer-reviewed studies to help us better understand how the pandemic has affected the full continuum of our patient's journey through our collective health care system. At ECH, we are observing an increase in readmissions for 'long covid', alcohol withdrawal, post-partum high blood pressure, and, readmissions for < 24 hours, as compared to prior to the pandemic. Measuring and focusing on readmissions is more important now than ever as this measure assesses our ability to ensure we are doing everything we can to optimize the care patients receive in our hospitals, and, that we have laser-sharp focus on discharge planning and optimizing the experience, coordination of care, and support our patients have once discharged from the acute care setting. Areas of focus are optimization of palliative care, 'meds to beds', and fine-tuned, personalized discharge education and planning.

		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend (showing at least the last 24 months of available data)	Rolling 12 Month Average	Measure Name
		Latest month	FYTD					
1	*Organizational Goal Readmission Index (All Patient All Cause Readmit) Observed/ Expected Premier Standard Risk Calculation Mode ***Latest data month: December 2021	0.93 (8.02%/8.62%)	1.00 (8.47%/8.47%)	0.93	0.92			1. Readmission Index - All Patient All Cause Readmit (Observed/Expected)

2. Mortality Index
    a. Definition--Updated 7/1/19 (JC)- Selection Criteria revised: new criteria excludes cases with Patient Type=Rehab, Psych & Hospice.
    For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.
    LCL is set to '0' if value is less than or equal to zero.
    b. This measure is HIGHLY dependent on accurate physician documentation in the medical record. Similar to the readmission index, the mortality index is based on having accurate documentation of the complexity and co-morbidities of our patients. We are very fortunate to have a 'best in class' CDI (clinical documentation integrity) team. There is a collaborative and collegial partnership with the CDI team, led by Cornel Delogramatic, MD, and the med staff.
    c. Our target is to have an observed/expected mortality ratio of 0.90 for FY22. In the month of January 2022, our performance was 0.80 (good), and, we are at 0.90 for FY22YTD. Here is a graphic to demonstrate the cause of death for the 46 patients who died in January.



    d. We also track Sepsis Mortality. During FY22 to date, 112 patients have died from sepsis at ECH. Of these patients, 15% also had COVID in the background of developing sepsis and dying.

3. Surgical Site Infections
    a. Definition-- Inclusion:
        i. Inclusion
            1. Based on NHSN defined criteria
            2. All surgical cases that are categorized as “clean wound class” and “clean-contaminated wound class” are considered for investigation
            3. SSIs that are classified: “deep –incisional” and “organ-space” are reportable.
        ii. Exclusion:
            1. All surgical cases that have a wound class of “contaminated” and “dirty”
            2. All surgical case that are considered an infection PATOS (present at time of surgery).
            3. All “superficial” SSIs
        iii. FY22 Target:
            1. Ent = same as last year =< 1.0 (SIR)
            2. For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.
            3. Lower Control Limit is not visible if it is less than or equal to zero.

    b. We have zero known surgical site infections for the month of January. Finalizing this number will be done 90 days after the completion of the month of January. Overall, the rate of surgical infections is well below (good) our target for FYYTD. A large part of this success we attribute to the successful roll out of the ERAS program.
    c. ERAS stands for Enhanced Recovery after Surgery. This is a proven evidence=-based protocol which is known to decrease surgical complications (and thus readmissions), opioid requirements and length of stay. Two significant components of a successful ERAS program are managing patient education and patient expectations prior to the surgical experience.

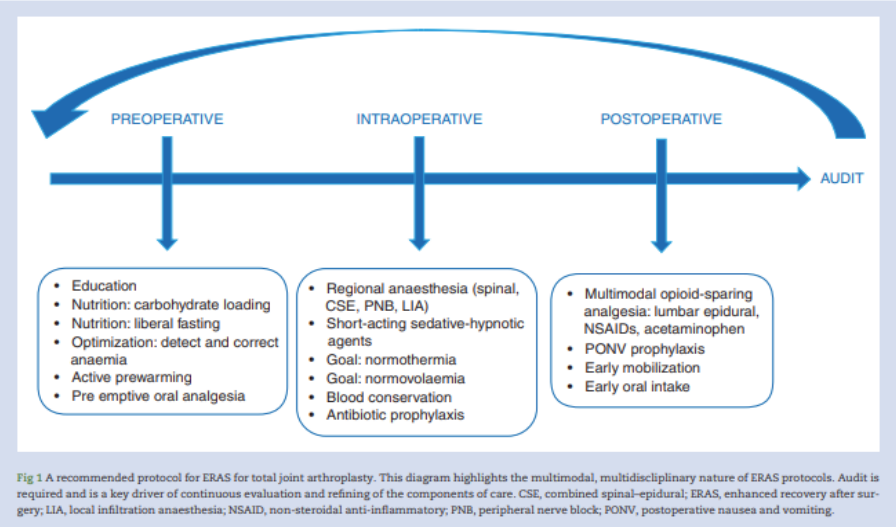


Fig 1 A recommended protocol for ERAS for total joint arthroplasty. This diagram highlights the multimodal, multidiscliplinary nature of ERAS protocols. Audit is required and is a key driver of continuous evaluation and refining of the components of care. CSE, combined spinal-epidural; ERAS, enhanced recovery after surgery; LIA, local infiltration anaesthesia; NSAID, non-steroidal anti-inflammatory; PNB, peripheral nerve block; PONV, postoperative nausea and vomiting.

Soffin and YaDeau British Journal of Anesthesia, 117 (S3) 62-72. 2016

    d. Here is a timeline for the implementation the elements of the program: