El Camino Health

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

Monday, May 2, 2022 – 5:30 pm
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

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

1-669-900-9128, MEETING CODE: 946 8250 4603#. 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 (04/04/2022) ***Information*** b. Report on Board Actions c. FY 22 Pacing Plan d. FY 22 Enterprise Quality Dashboard e. FY 23 Quality Committee Goals f. CDI Dashboard g. Core Measures h. 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 – 5:58**
6.	**PROPOSED FY23 ORGANIZATIONAL GOALS**	Holly Beeman, MD, MBA, Chief Quality Officer		**possible motion** **5:58 – 6:13**
7.	**EL CAMINO HEALTH MEDICAL NETWORK**	Vince Manoogian, Interim President ECHMN Ute Burness, VP of Quality and Payer Relations		**discussion** **6:13 - 6:33**

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
8.	**QUARTERLY BOARD QUALITY DASHBOARD REPORT**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:33 – 6:53**
9.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information 6:53 – 6:56**
10.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 6:56 – 6:57**
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 6:57 – 6:58**
12.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (04/04/2022) b. Quality Council Minutes (04/06/2022)	Julie Kliger, Quality Committee Chair		**motion required 6:58– 6:59**
13.	**CHAIR'S REPORT**	Julie Kliger, Quality Committee Chair		**information 6:59 – 7:04**
14.	*Health and Safety Code Section 32155* **Q3 FY22 QUALITY AND SAFETY REVIEW**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 7:04 – 7:14**
15.	*Health and Safety Code Section 32155* **CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer		**motion required 7:14 – 7:24**
16.	*Health and Safety Code Section 32155* **SERIOUS SAFETY/RED ALERT EVENT**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 7:24 – 7:29**
17.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:29 - 7:30**
18.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		**information 7:30– 7:31**
19.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 7:31 – 7:34**
20.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:34– 7:35 pm**

Next Meeting: 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, April 4, 2022
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

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

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 Ms. Simon were not present during roll call. Dr. Burn joined at 5:34 pm and Ms. Simon was absent. 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 Kliger asked if any Committee member would like to pull an item from the consent calendar. Ms. Falwell requested to pull item 3d – FY 22 Enterprise Quality Dashboard. Dr. Somersille requested to pull items 3c – FY 22 Pacing Plan, 3d – FY 22 Enterprise Quality Dashboard, and 3e – Value Based Purchasing Report. Ms. Falwell addressed the Cesarean Birth metric regarding how it has been above target for over a year and has not changed much. She requested to discuss what is being done to address this and what is the cause of this metric being static. Dr. Beeman shared that the OB Med Staff leadership focused on this measure. As part of their work to understand why the number is high, the c/s rate per provider was evaluated. Of the approximately 80 obstetricians on med staff who perform deliveries at ECH, 6 providers have a very high C-section rate. The 74 other OBs have a c/s rate below the target. One OB provider, in particular, has a very high c/s rate, and she is very motivated and engaged to reduce this rate. Her patients are primarily Indian and the majority request a cesarean section. A	***Consent Calendar approved***

	countermeasure in development is to provide culturally sensitive childbirth classes to provide education to this patient population on the risks and benefits of a vaginal birth vs elective cesarean section. Dr. Somersille addressed item 3c, requesting to add an Agenda item during the Quality Committee meetings to discuss our analysis of our Social Determinants of Health within the Healthcare District and what steps we are taking to help those marginalized within the community. Chair Kliger asked to table this item until we get to Agenda item 7 – Proposed FY23 Committee Meeting Dates to discuss the pacing plan. Dr. Somersille addressed page 41 – FY23 Organizational Goals versus the pulled consent calendar item 3d. Dr. Beeman addressed that this item will be discussed later on in the meeting during Agenda item 9 – Proposed FY23 Organizational Goals. Dr. Somersille asked about page 10 of item 3d regarding Sepsis Mortality and compliance with the Sepsis bundle. She asked if we have a coder that specifically addresses the documentation for Sepsis Mortality. Dr. Beeman shared that we do. Chair Kliger asked that we pause further discussion around Sepsis and move forward with the topic of approving the consent calendar. **Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (03/07/2022); For information: (b) Report on Board Actions, (c) FY 22 Pacing Plan, (d) FY 22 Enterprise Quality Dashboard (e) QC Follow-Up items **Movant**: Burn **Second**: Falwell **Ayes**: Kliger, Burn, Kan, Marfatia, Po, Sharma, Somersille, Ting, Falwell **Noes**: None **Abstain**: None **Absent**: Simon **Recused**: None	
4. CHAIR'S REPORT	Chair Kliger shared there is nothing to report.	
5. QUALITY COMMITTEE MEMBER ADDITION	Chair Kliger opened the discussion by sharing that two community members are interesting in joining the Quality Committee. The charter states the Quality Committee can have up to nine community members and currently there are four. She asked the committee if they would like to interview potential members or have an Ad-Hoc Committee complete the process? Dr. Burn shared that he is ok with the group vetting the candidates handling the process if they have a clear decision. If they are unsure, he would want it to come to the Quality	

	Committee. Dr. Po asked Mr. Ali to speak about the process that is in place for adding a Committee Member. Mr. Ali shared the ECHB Advisory Committee Community Member Nomination and Selection Process policy and what steps are needed to complete this request. Chair Kliger requested to table this due to the policy in place for recruitment and interviewing potential committee members. Dr. Ting expressed that if a Committee Member is added, the goal should be to identify what voice is missing from the committee and then attempt to identify candidates who can provide a perspective we do not already have on the committee such as someone who can bring a new voice to health equity. A couple of additional ideas are to bring someone on with statistical skills or a front line worker who can help identify ways to improve. Dr. Kan expressed that based on the robust discussion at the last Quality Committee meeting, it would be a good idea to add someone who has been a patient within the last year or two and rotate it annually.	
6. PATIENT STORY	Cheryl Reinking, CNO presented the Daisy award nominations that come directly from patients/families on written nomination forms regarding nurses that have made a special impression on the lives of our patients. Cheryl discusses in particular, the March Daisy nomination where the patient came to the award ceremony to recognize the nurse who had saved her life in the LG emergency department. This patient had not seen the nurse since CPR was performed and the nurse saved her life. Additional details about the Daisy award nominations are included in the memo.	
7. PROPOSED FY23 COMMITTEE MEETING DATES	Mr. Ali presented on behalf of the Governance Committee requesting feedback on the recommendation to the Pacing Plan for the Quality Committee. The changes came to the Governance Committee based on the assessment completed by Spencer Stuart who was hired to complete an overall assessment of the Board of Directors and the Committees. Mr. Ali highlighted two items around the recommendations: • The Committee would go from 10 meetings per year to 8 • Content has not changed – No items were removed and all items can still be paced into the Fiscal Year	

	Mr. Ali also noted Dr. Somersille's earlier request of adding Social Determinants of Health to the Pacing Plan for each meeting. Dr. Ting expressed that with the transition to the new Strategic Plan, now might not be the time to lower the number of meetings due to the items that need attention. Dr. Somersille expressed that a gradual reduction (i.e. 9) would be preferred if a reduction is to occur. Dr. Burn is comfortable having 8 meetings versus 10. Dr. Po is also in agreeance to reducing from 10 to 8 meetings and to ensure those meetings are substantial and strategic in conversation. Chair Kliger shared her concern that meeting length and density may be impacted if the number of meetings are reduced. Chair Kliger asked Dr. Holly Beeman to present regarding the content of the pacing plan. Dr. Holly Beeman, CQO presented a couple of elements of the charter that aren't currently discussed often that could be added. Those items are: • HRO Journey Updates • LEAN and what Performance improvement projects are being focused on. Additionally, Dr. Holly Beeman shared that Performance Improvement now reports to her. Dr. Holly Beeman echoed the need to talk about Social Determinants of Health and shared that she participated in the Carol Emmott Fellowship. This foundation's mission is to help eliminate racial and gender biases in healthcare. Dr. Beeman also acknowledged the desire to bring a Patient Voice to the committee and how we are ensuring the work being done in the Committee is aligned with the strategy.	
8. PROPOSED FY23 COMMITTEE GOALS	Dr. Holly Beeman, CQO presented on the FY23 Committee Goals and highlighted the following: • 2nd goal can be removed. Update the goal to have codified metrics around Social Determinants of Health • An additional goal can be around the HRO Journey updates Chair Kliger asked that we review the FY23 Committee Goals with those updated items at the next meeting on Monday, May 2, 2022.	
9. PROPOSED FY23 ORGANIZATIONAL GOALS	Dr. Holly Beeman, CQO presented the FY23 Organizational Goals and reviewed a new item listed under Quality and Safety called ECH Hospital Acquired Condition Composite and the 5 measures included in this composite.	

	Chair Kliger asked for clarification regarding next steps for the FY23 Organization Goals. Dr. Beeman shared that at the next Quality Committee, the FY23 goals will be reviewed in greater detail and she will share the ECHMN Composite.	
10. PUBLIC COMMUNICATION	There were no comments from the public.	
11. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 6:48 pm. **Movant**: Burn **Second**: Kan **Ayes**: Kliger, Burn, Kan, Marfatia, Po, Sharma, Somersille, Ting, Falwell **Noes**: None **Abstain**: None **Absent**: Simon **Recused**: None	***Adjourned to closed session at 6:48 pm***
12. AGENDA ITEM 19: RECONVENE OPEN SESSION/REPORT OUT	The open session reconvened at 7:31 pm. Agenda items 12-18 were addressed in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (03/07/2022), the Quality Council Minutes (03/02/2022), and the Medical Staff Credentialing and Privileges Report by unanimous vote by all committee members present.	
13. AGENDA ITEM 20: CLOSING WRAP UP	No additional comments	
14. AGENDA ITEM 21: ADJOURNMENT	**Motion**: To adjourn at 7:32 pm **Movant**: Kan **Second**: Burn **Ayes**: Kliger, Burn, Kan, Marfatia, Po, Sharma, Somersille, Ting, Falwell **Noes**: None **Abstain**: None **Absent**: Simon **Recused**: None	***Adjourned at 7:32 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: May 2, 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 once, and 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 also noted in this report.

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	April 13, 2022	- Board Assessment Follow-Up: FY23 El Camino Hospital Board Pacing Plan - Urology Call Panel Renewals for the Mountain View and Los Gatos Campuses - FY22 Period 08 Financials - Renewal of Enterprise Radiology Professional Services Agreement - FY21 Annual Report on Physician Financial Arrangements
ECHD Board	N/A	
Executive Compensation Committee	N/A	
Compliance Committee	March 30, 2022	- KPI Scorecard and Trends - Activity Log January 2022 - Activity Log February 2022 - Internal Audit Work Plan & Follow Up Table
Finance Committee	April 25, 2022	- MV & LG Gastroenterology Call Panel Renewal Agreements

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)

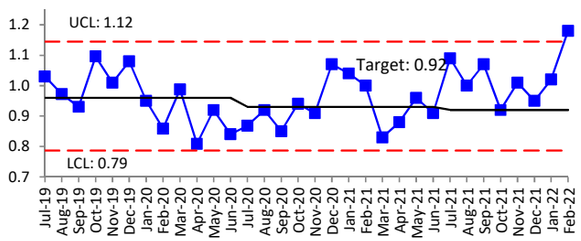
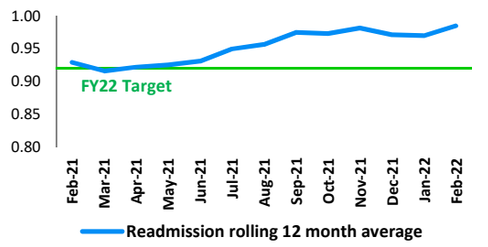
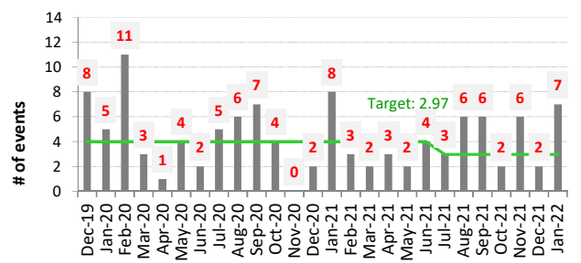
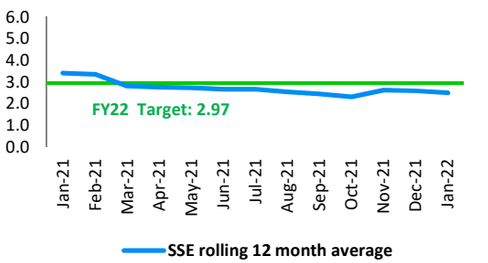
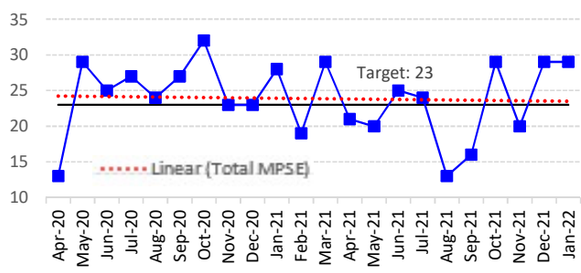
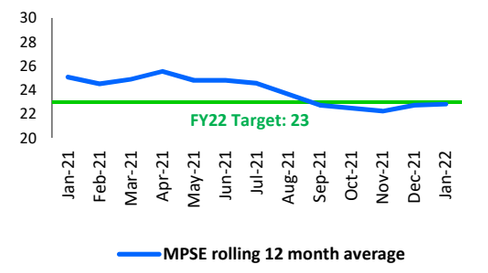
El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

March 2022 (unless otherwise specified)

Month to Board Quality Committee:

May, 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: February 2022*	1.18 (10.28%/8.71%)	1.03 (8.76%/8.51%)	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: January 2022*	7	2.50 (46/184219)	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: January 2022*	29	22.8/ mo (12 month rolling average)	320 (25/month) *(April 2020 to April 2021)*	304 (23/month) *(5% reduction from baseline)*		

Definitions and Additional Information

	Measure Name	Comments	Definition Owner	Definition	Source
1	**1. Readmission Index - All Patient All Cause Readmit (Observed/Expected)**		Holly Beeman, MD	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). *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	**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	**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 S. Shah 8/12/21 via email - 5% reduction from baseline**	iSafe Reports / EPSI Report / Safety Event Classification

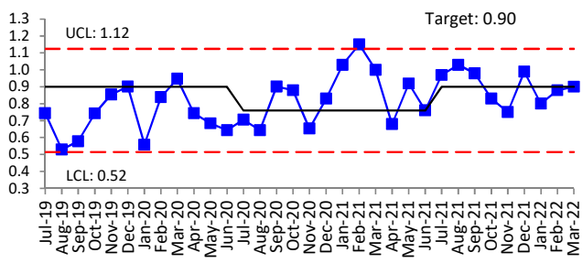
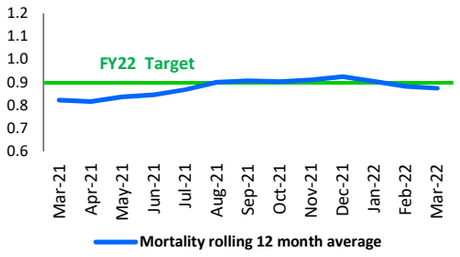
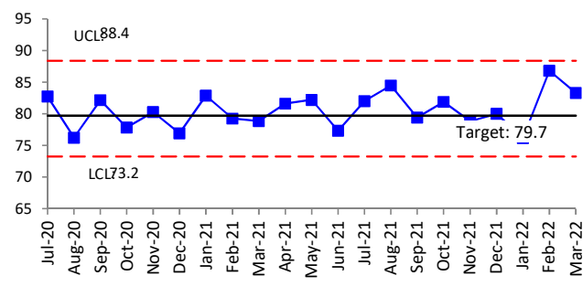
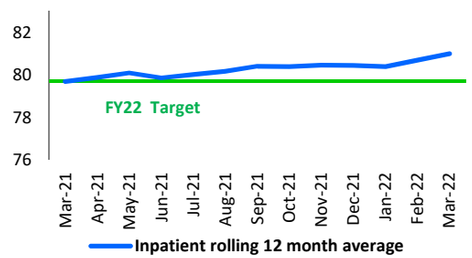
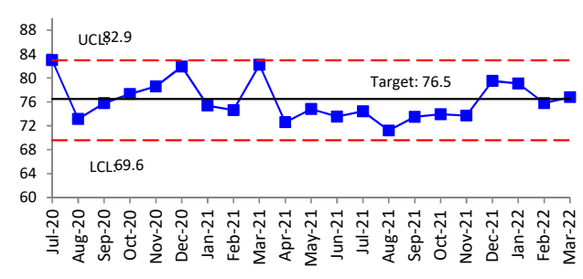
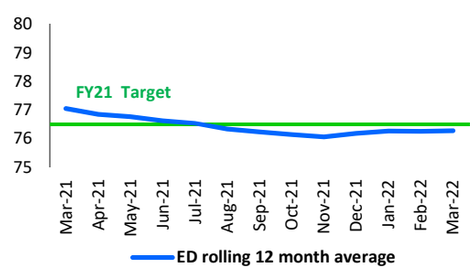
El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

March 2022 (unless otherwise specified)

Month to Board Quality Committee:

May, 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				
4	* Strategic Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: March 2022*	0.90 (1.97%/2.18%)	0.89 (1.85%/2.07%)	0.86	0.90		
5	*Organizational Goal **IP Units - HCAHPS Likelihood to Recommend -** *exec MBU,* **Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: March 2022*	83.3	81.3	79.6 (n=1983)	79.7		
6	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: March 2022*	76.8	75.5	76.1 (2347)	76.5		

Definitions and Additional Information

	Measure Name	Comments	Definition Owner	Definition	Source
4	**4. Mortality Index (Observed/Expected)**		Holly Beeman, MD	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
5	**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 10/18/21. 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	**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 10/18/21. 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**

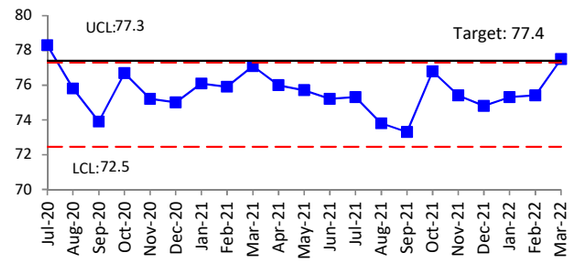
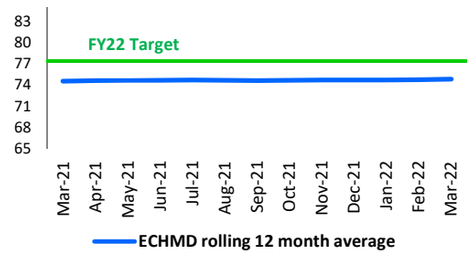
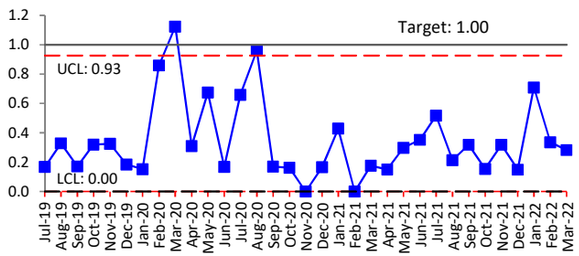
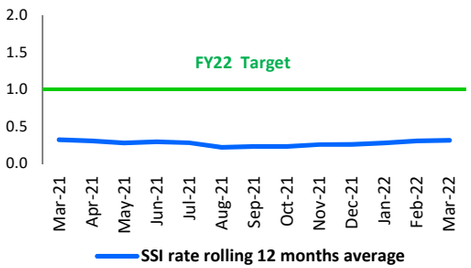
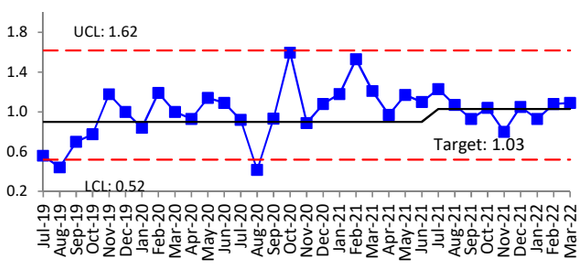
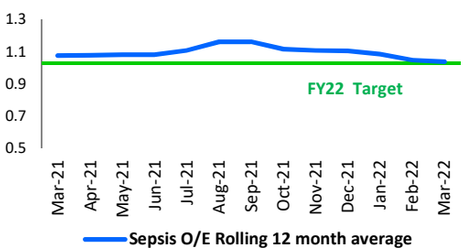
El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

March 2022 (unless otherwise specified)

Month to Board Quality Committee:

May, 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				
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: March 2022*	77.5	75.0	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: March 2022*	0.28 (1/353)	0.33 (17/5138)	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: March 2022*	1.09 (11.20%/10.26%)	1.02 (12.60%/12.33%)	1.08 (12.86%/11.87%)	1.03		

Definitions and Additional Information

	Measure Name	Comments	Definition Owner	Definition	Source
7	**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 0/18/21. 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**
8	**8. Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100**		Holly Beeman, MD/ 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 - Infection Control**
9	**9. Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)*		Jessica Harkey, Holly Beeman, MD	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**

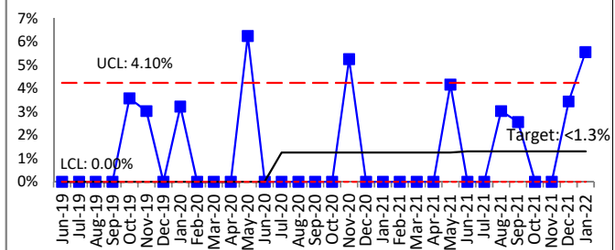
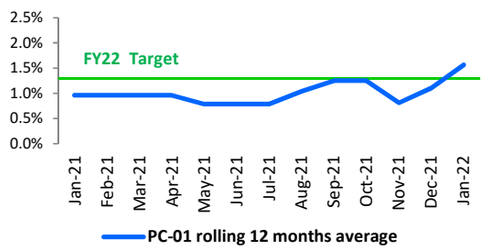
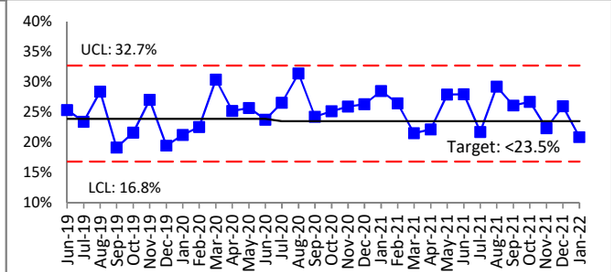
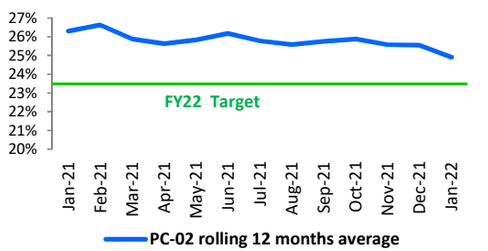
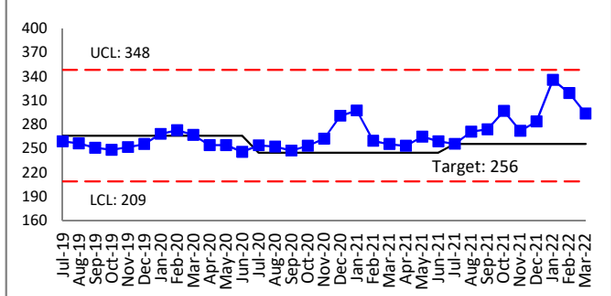
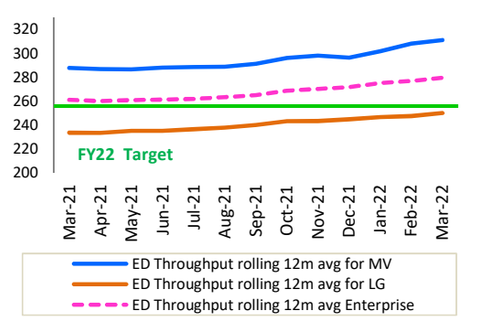
El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

March 2022 (unless otherwise specified)

Month to Board Quality Committee:

May, 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				
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) ****Latest data month: January 2022*	MV: 0.0% (0/16) LG: 50.0% (1/2) ENT: 5.6% (1/18)	MV: 0.6% (1/168) LG: 6.1% (3/49) ENT: 1.8% (4/217)	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: January 2022*	MV: 21.4% (27/126) LG: 18.9% (7/37) ENT: 20.9% (34/163)	MV: 25.7% (281/1092) LG: 21.0% (54/257) ENT: 24.8% (335/1349)	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, & transfer between sites)* *Latest data month: March 2022*	MV: 320 min LG: 268 min Ent: 294 min	MV: 317 min LG: 258 min Ent: 288 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 January only

** Readmission data are available up to February

Report updated: 4/18/2022; final: 4/19/22

Definitions and Additional Information

	Measure Name	Comments	Definition Owner	Definition	Source
10	**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**
11	**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	**12. Patient Throughput-Median Time from Arrival to ED Departure** (excludes psychiatric patients, patients expired in the ED, newborns, & 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**

El Camino Health

FY23 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

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

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

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

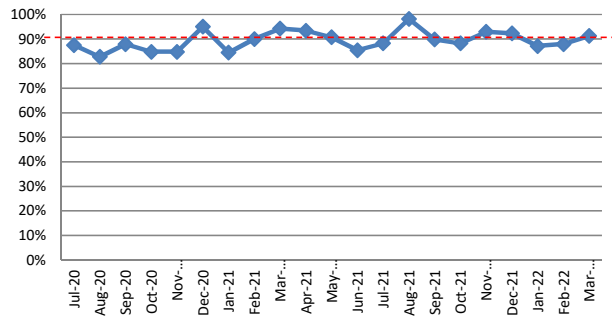
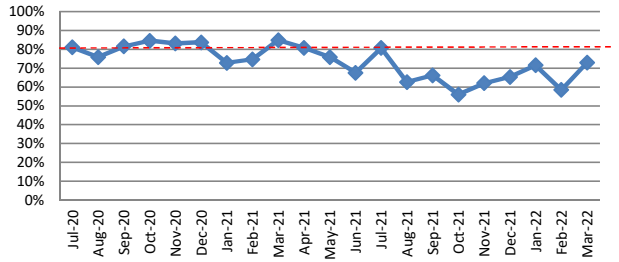
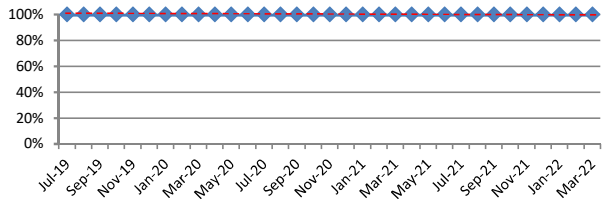
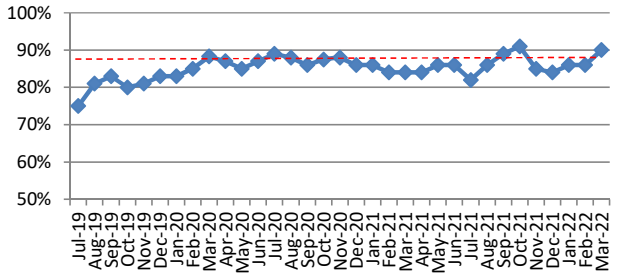
GOALS	TIMELINE	METRICS
1. Review the Hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality	- FY22 Achievement and Metrics for FY22 (Q1 FY23) - Review FY23 Incentive Goal recommendations for Quality, Safety and Patient Experience measures	Review management proposals; provide feedback and make recommendations to the Board
2. Review the milestones and outcome metrics of the ECH High Reliability implementation.	HRO Journey in process currently with classes underway April 2022 with plans for ongoing education throughout FY22 and FY23.	HRO: Serious Safety Event Rate and Culture of Safety Survey.
3. Reducing health care disparities is a quality priority for the enterprise	Biannual report to Quality Committee FY23	Monitor the effectiveness of ECH activities to reduce health care disparities in the individuals we serve
4. Review Quality, Patient Care and Patient Experience reports and dashboards	- Review reports per Pacing Plan timeline.	Explanation of measure methodology and benchmarks included with each report.
5. Review Board Quality STEEEP Dashboard and propose changes as appropriate	Quarterly	Review Dashboard and Recommend Changes to the Board
6. All committee members regularly attend and are engaged in committee meeting preparation and discussions	Using closing wrap up time, review quarterly at the end of the meeting	- Attend 2/3 of all meetings in person - Actively participate in discussions at each meeting

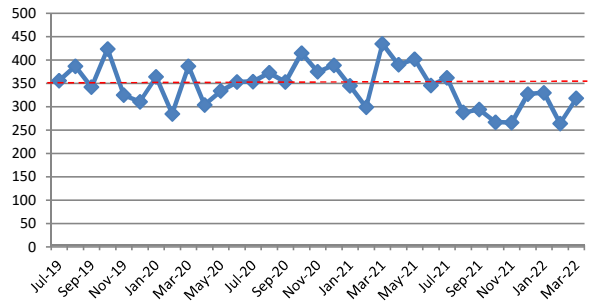
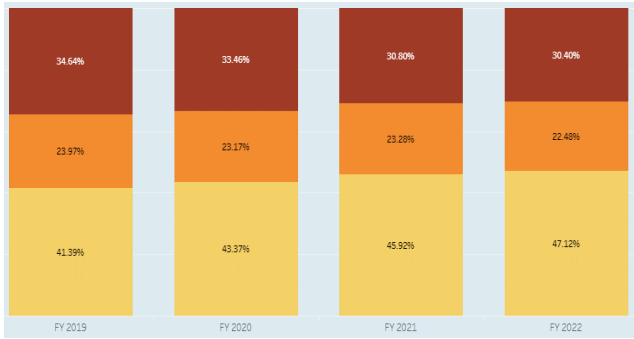
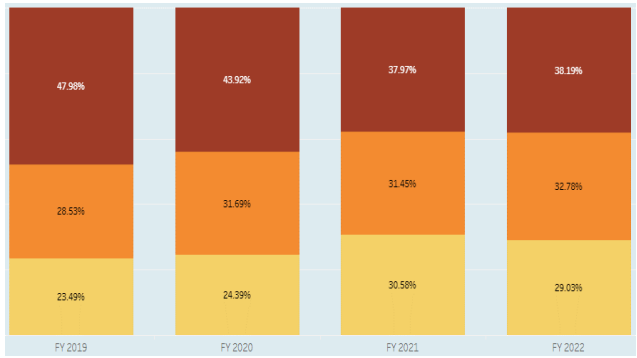
SUBMITTED BY: **Chair**: Julie Kliger, MPA, BSN
Executive Sponsor: Holly Beeman, MD, MBDA, Chief Quality Officer

El Camino Health

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

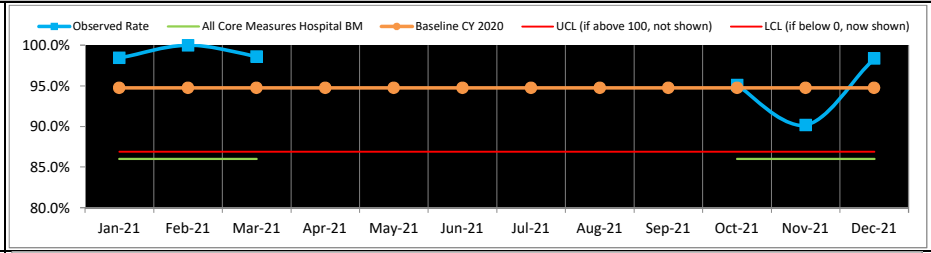
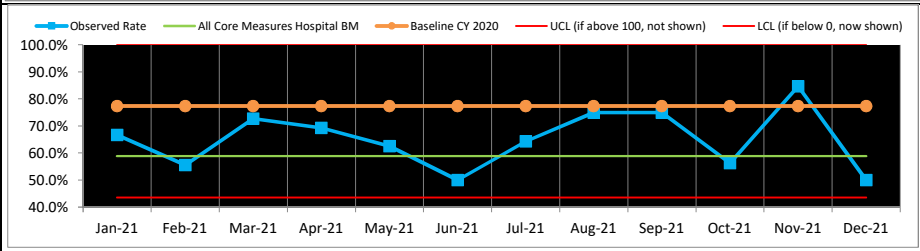
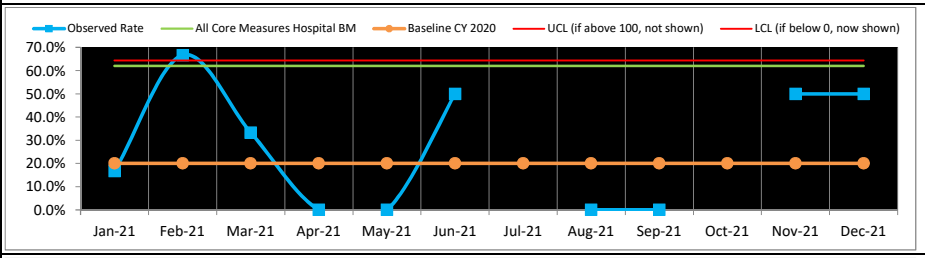
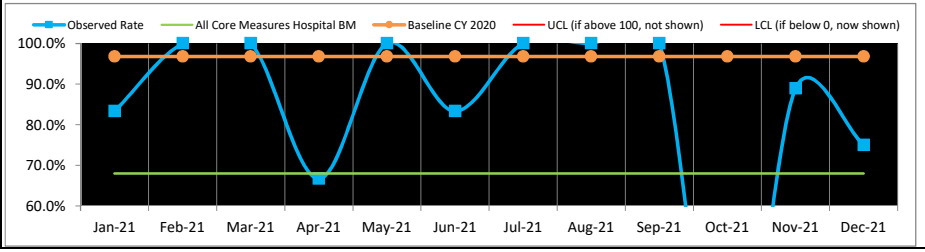
As of Apr 15, 2022

				Baseline	FY21 Goal	Trend	Comments
CDI Coverage		**Performance**		**FY2021**	**FY2022 goal**		
1	**Medicare** **Source: iCare CDI Productivity report*	**March 2022** 593/541 **91%**	**FYTD** **91%**	**88%**	**90%**		CDI team continues to prioritize Medicare accounts despite covering multiple additional documentation projects. Due to increased efficiency and planning Medicare coverage by CDI team did not suffer during CDI Outpatient expansion. The coverage rate remains at 91% FYTD slightly above the goal established for the fiscal year. After almost 2 years the team is fully staffed and working diligently to impact the quality, complinace and financial outcomes.
2	**All Payor** **Source: iCare CDI Productivity report*	**March 2022** 1292/843 **73%**	**FYTD** **66%**	**79%**	**80%**		The priority of the CDI department is to cover the entire Inpatient population, that benefits the quality scores a lot, at this time, due to short staff, priority was on Medicare and Medicare Advantage payers (DRG based) and the All-Payer coverage had a downtrend. With the addition of new staff in January, the numbers should start uptrending.
Physician Response		**Performance**		**FY2021**	**FY 2022 goal**		
3	**Query Response Rate** **Source: iCare CDI Query report*	**March 2022** **100%**	**FYTD** **100%**	100%	100%		The response rate remains 100% mainly due to solid adherence to Physician Query policy, escalation protocols, and robust physician engagement. The rate is the highest compared to similar programs around the nation. Epic has placed El Camino Hospital in the top 25 Epic users nationwide with the highest physicians response rate.
4	**Query Agree Rate** **Source: iCare CDI Query report*	**March 2022** **90%**	**FYTD** **87%**	87%	89%		The agreement rate achieved for the second time ever recorded the milestone of 90%. There is a direct correlation between a lower number of queries and a better response rate. Nonetheless, I think the last results also have to do with the high visibility of the CDI specialists and the optimizations of the query templates that mainly contributed to the high response rate.

	Queries volume	Performance		FY2021	FY 2022 goal		
5	**Query volumes** **Source: iCare CDI Query report*	**March 2022** **318** **34**% of of all reviewed accounts	**FYTD Avg.** **300** **30**% of all reviewed accounts	Queries Avg. **370**	Query 40% of all reviewed accounts		The query rate sustained a contraction mainly attributed to a temporary staff shortage, and some Epic disruptions of the query process suffered at the beginning of the calendar year 2022. Epic processes have been implemented to avoid future crises, and with the addition of 2 new FTEs we should shortly experience an increase in volumes.
6	**Medical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient) *Source: Tableau CDI Dashboard *Higher MCC/CC Capture Rate better reflects severity of population*	**March 2022** **MCC** 45% **CC** 21% **NCC** 33%	**N/A**	**Nat 80th% CMS 2018** MCC 48% CC 25% No CC 26%	**Nat 80th% CMS 2019**		The Medical CC/MCC rcontinue to increase year over year, a reflection of an advance CDI program and a successful medical staff education regarding clinical documentation concepts.
7	**Surgical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient) *Tableau CDI Dashboard *Higher MCC/CC Capture Rate better reflects severity of population*	**March 2022** **MCC** 26% **CC** 34% **NCC** 40%	**N/A**	**Nat 80th% CMS 2018** MCC 28% CC 31% No CC 41%	**Nat 80th% CMS 2019**		Surgical cases make up 20-30% of our Medicare patient volume. The most significant impact on CMI, GMLOS will be by increased Surgical CC/ MCC rate. The numbers are relatively higher than in previous years but lower than FY 2021 impacted mainly by the pandemic trends (low volumes but highly complex and severe patients).

El Camino Health

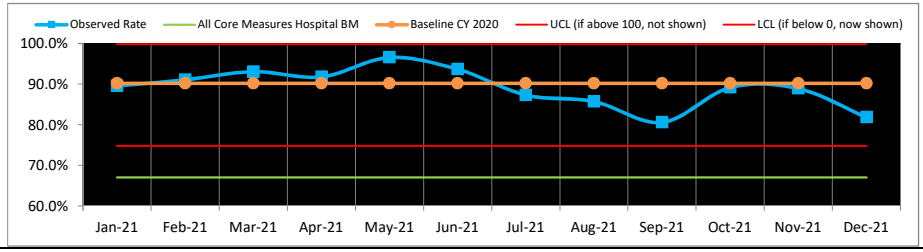
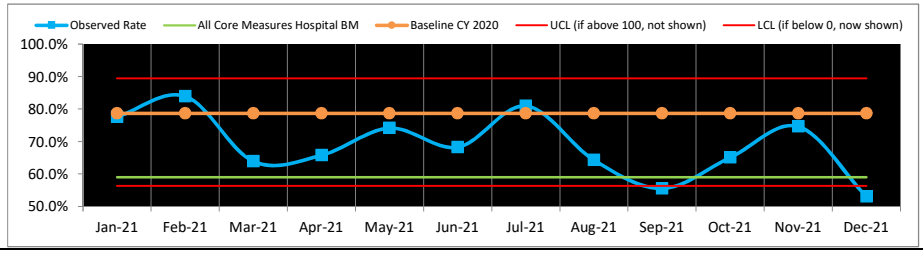
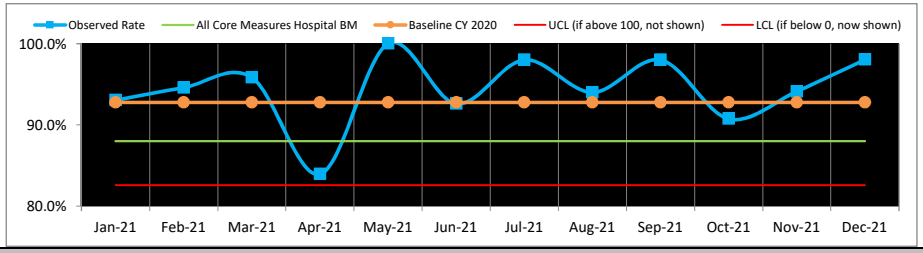
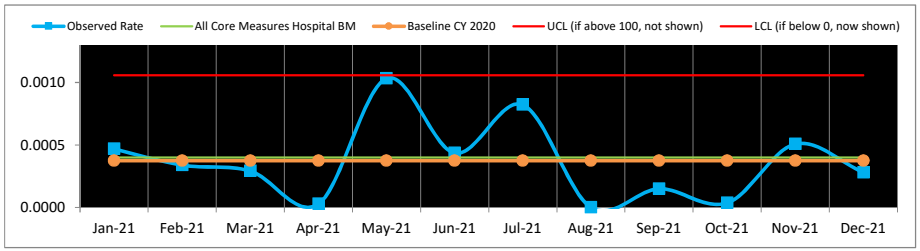
Calendar Year 2021 Performance - Core Measures (HBIPS) - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	CY 2021 Performance	Baseline CY 2020	All Core Measures Hospitals Jan-Dec 2021 Benchmark	Trend Graph
HOSPITAL BASED INPATIENT PYSCHIATRIC SERVICES (HBIPS)					
IMM-2 Influenza Immunization **FINALIZED** | *Data Source : IBM* *Latest Data Month:* ***December 2021**** ***Data only capture for October to March months**	98.4% (60/61)	96.7% (380/393)	94.8% (361/381)	86.0%	
HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification **FINALIZED** | *Data Source : IBM* *Latest Data Month:* *DECEMBER 2021*	50.0% (7/14)	65.2% (88/135)	77.4% (82/106)	58.9%	
PC-TOB Perfect Care - Tobacco Use **FINALIZED** | *Data Source : IBM* *Latest Data Month:* *DECEMBER 2021*	50.0% (2/4)	34.4% (11/32)	20.0% (13/65)	62.0%	
PC-SUB Perfect Care - Substance Abuse **FINALIZED** | *Data Source : IBM* *Latest Data Month:* *DECEMBER 2021*	75.0% (6/8)	86.8% (46/53)	96.8% (91/94)	68.0%	

Comments	CY 2021 Definition	Definition Owner	Work Group	Source
IMM-2 Influenza Immunization Patients assessed and given influenza vaccination. Target goal is 100%; CY 2021 rate is 97%.	Numerator: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated. Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October through March. Excludes patients less than 6 months of age, patients who expire prior to hospital discharge, patients with an organ transplant during the current hospitalization, patients with hospital discharges Oct 1 through March 31 when the provider's vaccine supply is on order but has not yet been received, patients who are transferred or discharged to another hospital, or patients who leave AMA. Definition: Documentation of the patient's vaccination status during this influenza season. If found to be a candidate for the influenza vaccine, documentation that the influenza vaccine was given during this hospitalization.	**CMS/TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**
Patients Discharged on multiple antipsychotic medications with appropriate justification. Target goal is 80%; CY 2021 rate is 65% Reports were created and shared monthly to BHS leadership to identify patients discharged on two or more antipsychotic medications without appropriate supporting documentation. Education efforts targeted to remind providers that even if they prescribed antipsychotic (e.g. Abilify) to treat depression, it's stil counted as antipsychotic. Also not to bypass or work-around the hardwired discharge documentation of reason for 2 or more antipsychotics by answering NO.	Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification Denominator Statement: Psychiatric inpatient discharges	**TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**
PC-TOB Perfect Care - Tobacco Use-Target goal is 80% CY 2021 rate is 34% Each element has to be met to pass the measure. Current improvement work related to these measures includes Social Worker's Quitline referral, prescribing of FDA approved tobacco cessation drugs while inpatient and upon discharge. . Daily monitoring to identify current tobacco users to ensure proper interventios are implemented- quality collaborating with MHAS asst. clinical managers and hospital supervisors.	No tob 1 , same Tob 2 and 3	**TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**
PC-SUB Perfect Care - Substance Abuse- Target goal is 80% CY 2021 rate is 87%	No Sub 1, same SUB 2 and 3	**TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**

El Camino Health

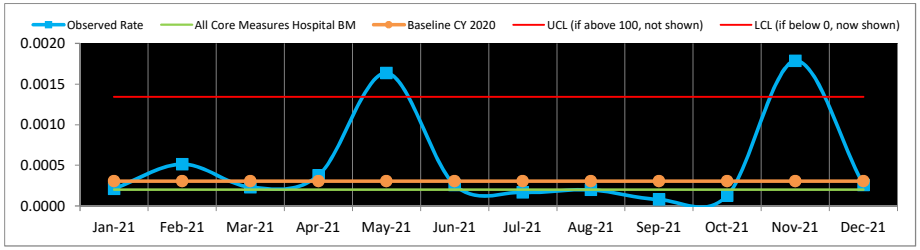
Calendar Year 2021 Performance - Core Measures (HBIPS) - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	CY 2021 Performance	Baseline CY 2020	All Core Measures Hospitals Jan-Dec 2021 Benchmark	Trend Graph
TR-1 Transition Record with Specified Elements Received by Discharged Patients **FINALIZED** | *Data Source : IBM* *Latest Data Month: DECEMBER 2021*	81.8% (54/66)	89.0% (717/806)	90.2% (660/732)	67.0%	
TR-2 Timely Transmission of Transition Record **FINALIZED** | *Data Source : IBM* *Latest Data Month: DECEMBER 2021*	53.0% (35/66)	68.4% (551/806)	78.7% (576/732)	59.0%	
MET-1 Screening for Metabolic Disorders **FINALIZED** | *Data Source : IBM* *Latest Data Month: DECEMBER 2021*	98.0% (50/51)	94.2% (551/585)	92.8% (449/484)	88.0%	
RESTRAINTS AND SECLUSIONS					
HBIPS-2* Hours of Physical Restraint Use (per 1000 patient hours) (lower = better) **FINALIZED** | *Data Source : IBM* *Latest Data Month: DECEMBER 2021* *Event measures are calculated by event occurrence date	0.0003 (6.7333/24048)	0.0003 (93.6165/269784)	0.0004 (70.1667/187488)	0.0004	

Comments	CY 2021 Definition	Definition Owner	Work Group	Source
TR-1 Transition Record with Specified Elements Received by Discharged Patients Target goal is 75% CY 2021 rate is 89%	Numerator: Psychiatric inpatients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all 11 required elements. Denominator: Psychiatric inpatients, regardless of age, discharged from the IPF to home/self-care or any other site of care.	**CMS/TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**
TR-2 Timely Transmission of Transition Record- Target goal is 75%; CY 2021 rate is 68%	Numerator: Psychiatric inpatients for whom a transition record, which included all 11 elements, was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. Denominator: Psychiatric inpatients, regardless of age, discharged from an IPF to home/self-care or any other site of care.	**CMS/TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**
MET-1 Screening for Metabolic Disorders - Comprehensive screening currently defined to include: Body mass index A1C or glucose test Blood pressure Lipid panel Total cholesterol Low density lipoprotein High density lipoprotein Triglycerides. Target goal is 75%; CY 2021 rate is 94%	The numerator is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) glucose or HbA1c; and (4) a lipid panel. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or at another facility for which records are available to the reporting facility. The denominator includes IPF patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period. The measure excludes patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical or psychological condition and patients with a length of stay equal to or greater than 365 days or equal to or less than 3 days. Screening for Metabolic Disorders Studies show that antipsychotics increase the risk of metabolic syndrome.1 Metabolic syndrome is a cluster of conditions that occur together, including excess body fat around the waist, high blood sugar, high cholesterol, and high blood pressure, all of which increase the risk of coronary artery disease, stroke, and type 2 diabetes.	**CMS/TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**
HBIPS-2 Hours of Physical Restraint Use (per 1000 patient hours) Target goal is 0.0004; CY 2021 rate is 0.0003	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	**TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**

El Camino Health

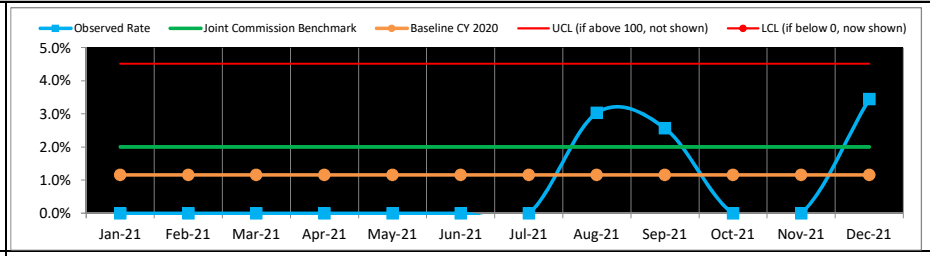
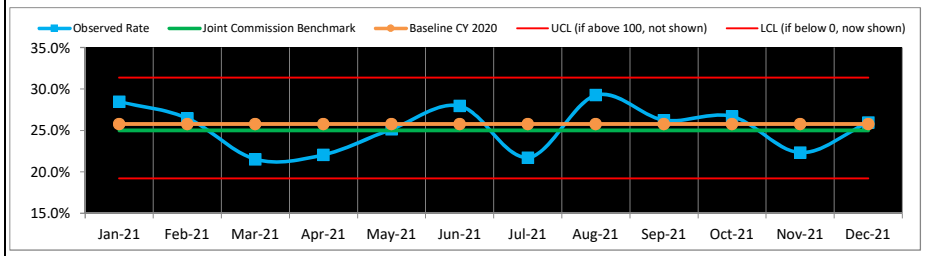
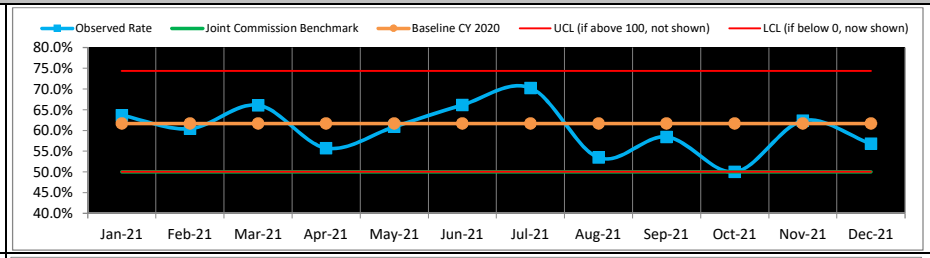
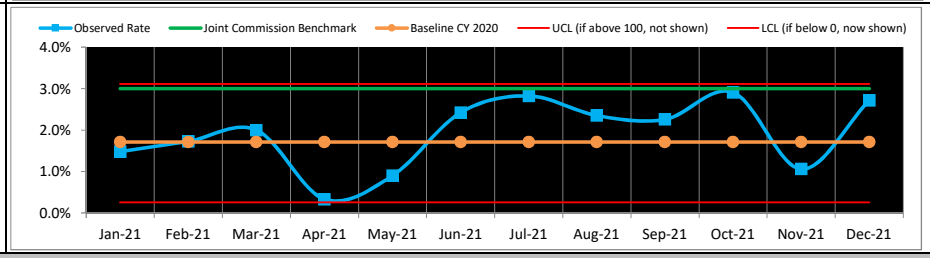
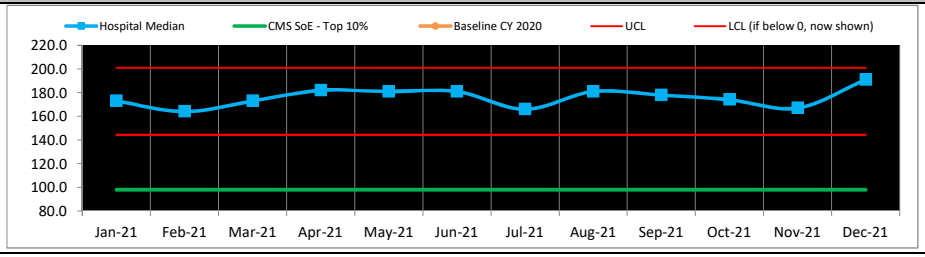
Calendar Year 2021 Performance - Core Measures (HBIPS) - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	CY 2021 Performance	Baseline CY 2020	All Core Measures Hospitals Jan-Dec 2021 Benchmark	Trend Graph
HBIPS-3* Hours of Seclusion Use (per 1000 patient hours) (lower = better) **FINALIZED** | *Data Source : IBM Latest Data Month: DECEMBER 2021* *Event measures are calculated by event occurrence date	0.0003 (6.1833/24048)	0.0005 (131.1335/269784)	0.0003 (57.2167/187488)	0.0002	

Comments	CY 2021 Definition	Definition Owner	Work Group	Source
HBIPS-3 Hours of Seclusion Use (per 1000 patient hours) Target goal is 0.0003; CY 2021 rate is 0.0005	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	**TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**

El Camino Health

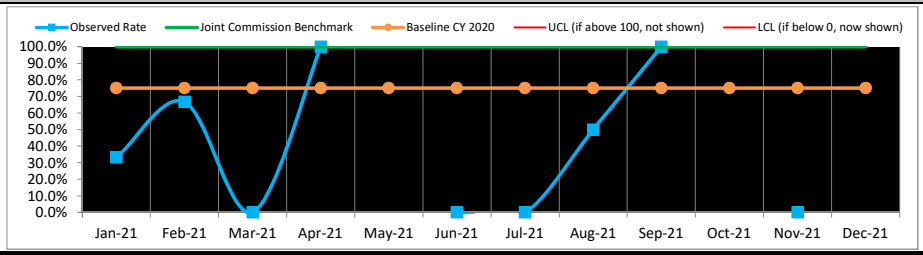
Core Measures Dashboard (non-HBIPS) - CY 2021 Performance - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	CY 2021 Performance	Baseline CY 2020	Target	Trend Graph
PERINATAL CARE MOTHER					
PC-01 Elective Delivery Prior to 39 weeks gestation (lower = better) **FINALIZED** | *Data Source : IBM* *Latest Data Month:* *DECEMBER 2021*	ENT: 3.4% (1/29) MV: 0.0% (0/17) LG: 8.3% (1/12)	ENT: 0.8% (3/365) MV: 0.4% (1/279) LG: 2.3% (2/86)	ENT: 1.2% (4/345) MV: 1.4% (4/287) LG: 0.0% (0/58)	2% (Joint Commission Benchmark)	
PC-02 Cesarean Birth (lower = better) **FINALIZED** | *Data Source : IBM* *Latest Data Month:* *DECEMBER 2021*	ENT: 26.0% (54/208) MV: 26.0% (45/173) LG: 25.7% (9/35)	ENT: 25.4% (534/2105) MV: 26.5% (451/1704) LG: 20.7% (83/401)	ENT: 25.8% (499/1936) MV: 26.5% (433/1631) LG: 21.6% (66/305)	25% (Joint Commission Benchmark)	
PERINATAL CARE BABIES					
PC-05 Exclusive Breast Milk Feeding **FINALIZED** | *Data Source : IBM* *Latest Data Month:* *DECEMBER 2021*	ENT: 56.8% (42/74) MV: 59.0% (36/61) LG: 46.2% (6/13)	ENT: 60.2% (481/799) MV: 57.7% (376/652) LG: 71.4% (105/147)	ENT: 61.7% (463/751) MV: 58.1% (369/635) LG: 81.0% (94/116)	50% (Joint Commission Benchmark)	
PC-06 Unexpected Complications in Term Newborns (lower = better) **FINALIZED** | *Data Source : IBM* *Latest Data Month:* *DECEMBER 2021*	ENT: 2.7% (10/368) MV: 2.3% (7/298) LG: 4.3% (3/70)	ENT: 2.0% (79/4028) MV: 1.7% (56/3249) LG: 3.0% (23/779)	ENT: 1.7% (63/3683) MV: 1.4% (44/3086) LG: 3.2% (19/597)	3% (Joint Commission Benchmark)	
ED THROUGHPUT					
OP-18b Median Time from ED Arrival to ED Departure for Discharged ED Patients (lower = better) **FINALIZED** | *Data Source : IBM* *Latest Data Month:* *DECEMBER 2021*	ENT: 191 mins MV: 204 mins LG: 159.5 mins	ENT: 177 mins MV: 185 min LG: 134.5 min	ENT: 172 mins MV: 188 mins LG: 126.4 mins	< 98 mins (CMS Standard of Excellence - Top 10% of Hospitals)	

Comments	CY 2020 Definition	Definition Owner	Work Group	Source
PC01- Elective Delivery Prior to 39 weeks gestation- Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery wasn't medically necessary. Also known as Early Elective Delivery (EED) Target goal is 0%; CY 2021 Performance: 0.8% Statistically topped out national 2% and state 2% and was recently removed from Value Based Purchasing Program. MCH has an EED tracking system and reach out to providers to reschedule as needed. EED is tracked and closely monitored to avoid unindicated cases.	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	**TJC**	**Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to peer review coordinator**	**IBM CareDiscovery Quality Measures**
PC02- Cesarean Birth- Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. Target goal of 23.9%; CY 2021 Performance is 25.4% The providers get their score card generally every quarter so they can see how they are doing along with their peers;OB Task Force has been evaluating where they can make system improvements to reduce unnecessary NTSV.	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	**TJC**	**Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator**	**IBM CareDiscovery Quality Measures**
PC05- Exclusive Breast Milk Feeding- Newborns that were fed breast milk only since birth during the entire hospitalization. Target goal is 70%; CY 2021 Performance: 60% Our target compliance rate of 70%- this gives us 30% allowance for cases with maternal /infant indocators to supplement with formula feeding. Medical reasons are not given credits or exempted e.g. Jaundice with TsB @ high risk or requiring phototherapy, hypoglycemia, weight loss >7% and dehydration. • Senate Bill 402, De Leon, Health and Safety Code 123367; Requires all general acute care hospitals and special hospitals with perinatal units to adopt, by January 1, 2025, The Ten Steps to Successful Breastfeeding adopt baby friendly 10 steps to successful breastfeeding	Numerator Statement: Newborns that were fed breast milk only since birth Denominator Statement: Single term newborns discharged alive from the hospital	**TJC**	**Quarterly meeting/emails with L&D nursing leadership**	**IBM CareDiscovery Quality Measures**
PC06- Unexpected Complications in Term Newborns- TJC's new core measure is intended to track moderate-to-severe adverse outcomes of healthy infants without preexisting conditions. Target goal is 0%; CY 2021 Performance: 2% This measure is intended to track moderate to severe adverse outcomes of healthy infants without pre-existing conditions. Failed cases are referred to peer review coordinators/ nurses for further investigation.	Numerator Statement: Newborns with severe complications and moderate complications Denominator Statement: Liveborn single term newborns 2500 gm or over in birth weight. This measure simply asks: of babies without preexisting conditions (no preemies, multiple gestations, birth defects or other fetal conditions) and who are normally grown and were not exposed to maternal drug use, how many had severe or moderate neonatal complications?	**TJC**	**Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator**	**IBM CareDiscovery Quality Measures**
OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients-Median time patients spent in the emergency department before leaving from the visit. Target goal is 180 minutes or less; CY 2021 rate is ENT:177 mins; MV:185 mins; LG:134.5 mins	"Numerator -Time (in minutes) from ED arrival to ED departure for patients discharged from the ED - Reporting Measure Denominator -Any ED Patient from the facility's emergency department, not expired Included Populations: Any ED patient from the facility's emergency department Excluded Populations: Patients who expired in the emergency department"	**Hospital OQR Specifications Manual**		**IBM CareDiscovery Quality Measures**

El Camino Health

Core Measures Dashboard (non-HBIPS) - CY 2021 Performance - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	CY 2021 Performance	Baseline CY 2020	Target	Trend Graph
OUTPATIENT MEASURES					
OP-23 Head CT or MRI Scan Results fro Acute Ischemic Stroke or Hemorrhagic Stroke **FINALIZED** | *Data Source : IBM* *Latest Data Month: DECEMBER 2021*	No Case in December 2021	46.7% (7/15)	75.0% (6/8)	100% (CMS Standard of Excellence - Top 10% of Hospitals)	

Comments	CY 2020 Definition	Definition Owner	Work Group	Source
OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke- Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival.Target goal is 100%; CY 2021 47% The metric only includes patients who arrive within 2 hours of last known well explaining the low denominator . Currently, we are a Thrombectomy-capable Stroke Center in MV and Primary Stroke Center in LG so we continue to transfer certain cases to align with insurance and/or for higher level of care (primarily SAH cases in MV, and possible thrombectomy cases in LG.)	Numerator -ED Acute Ischemic or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the time last known well, with an order for a head CT or MRI scan whose time from ED arrival to interpretation of the Head CT scan is within 45 minutes of arrival Denominator -ED Acute Ischemic or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the time last known well with an order for a head CT or MRI scan	**Hospital OQR Specifications Manual**	**Shared with Christine Kilkenny (monthly) /Stroke Committee (quarterly prn)**	**IBM CareDiscovery Quality Measures**

As of: 04/04/22

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
3/7/2022	Julie Kliger	Follow up Disscussion - Include patients in Quality Committee Meetings. Dr. Burn, Cheryl and Dr. Beeman will explore other models of this process.	
4/4/2022	Holly Beeman	Update FY23 Quality Committee Goals to include: DEI, HRO	5/2/2022

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: April 26, 2022
Subject: Patient Experience Feedback via 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: This past month the hospital received this handwritten letter from a patient who expressed dissatisfaction with their care over three different episodes at the LG and MV campuses.

2. Authority: To provide insight into one patient's experience while at El Camino Health.

3. Background: The patient wrote this letter indicating his concern with care, but also expressed a willingness to participate in assisting the hospital with improvements to care practices.

4. Assessment: The hospital met with the patient as requested to learn about his experiences and how we might engage him in our improvement efforts.

5. Other Reviews: None

6. Outcomes: The patient shared his specific concerns which we are addressing. In addition, the patient agreed to serve on the patient and family advisory council (PFAC).

List of Attachments:

1. See patient letter

Suggested Committee Discussion Questions:

1. What is your usual response to written letters to ECH?

2. What is the role of the PFAC?

I am a 67 year old severely disabled senior who has been a patient of PAMF for 14-years now. I have been a patient at El Camino Hospital 3-times (1-at Los Gatos and 2-at Mt. View). All three times the staff has either managed to injure me or cause permanent injury.

This letter is written in good faith with a desire to assist you in continuing to make El Camino Hospital the hospital of choice for bay area residents. The statute of limitations has long ago expired so I am obviously not interested in pursuing legal recourse. I sincerely want to partner with you to improve the health care provided by El Camino Hospital for the good of all involved. I Engage in the same good faith efforts with PAMF with wonderful results.

I would respectfully like to request a meeting with you in person to discuss these three situations. I have had all three COVID shots and have never been diagnosed with COVID. I will also wear a mask. I sincerely hope you will agree to meet with me.

El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: May 2, 2022
Subject: El Camino Health FY23 Proposed Strategic Goals

Purpose: Review proposed strategic goals for FY23

Summary:

1. Situation: ECH Management has developed Organizational Quality, Safety and Experience Goals for FY23. The proposed goals were reviewed at the March 4, 2022 Quality Committee Meeting. A new metric, the ECH Hospital Acquired Condition (HAC) index was introduced with a commitment to bring details on the definitions, data sources and benchmarks to be shared with the Quality Committee on May 2, 2022.

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

3. Background: The enterprise is underway with our High Reliability Organization journey with an enterprise goal of Zero Harm. In alignment with our focus on safety, the Quality and Safety organizational goal for FY23 will monitor five measures of patient harm; Clostridium Difficile infection, surgical site infection, inpatient falls, hospital acquired pressure injuries and non-ventilator hospital acquired pneumonia.

4. Assessment:
   - **A.** Hospital Acquired Infection Index
     - i. ECH Hospital Acquired Condition Index. This index brings focused attention to our performance in five measures. The 5 measures which make up the composite are:
       1. C. difficile infection rate
       2. Inpatient fall rate
       3. Non-ventilator pneumonia rate (nvHAP)
       4. Hospital acquired pressure injury rate (HAPI)
       5. Surgical site infection rate (SSI)
     - ii. The attachment, ECH HAC Index, provides information on the definition source, the measure definition as well as our performance for each measure for FY22 YTD, FY21 and FY20. We have had increasing number/rates of patient harm events in FY22 compared to prior years.
     - iii. ECHMN Quality Metrics will be discussed in detail in the ECHMN report on the agenda in open session for this meeting.
   - **B.** Service Goals
     - i. Likelihood to recommend for inpatient and ECHMN will continue to be performance goals for FY23.

List of Attachments: ECH HAC Index

					FY 2022*				FY 2021				FY 2020			
	Measure	Definition Source	Measure Definition	FY22* reporting measure date	Numerator	Rate YTD	Weight	Weighted Rate	Numerator	Rate	Weight	Weighted Rate	Numerator	Rate	Weight	Weighted Rate
1	**C-diff**	NHSN/CDC	Infection Rate is predicted infections to meet Target/Goal: NHSN SIR. Inclusion criteria: in-patients only 1. Based on NHSN defined criteria 2. ALL positive C.diff Toxin/antigen lab tests that result on or after the patient's 4th day of hospitalization. Exclusion criteria: Out-patients and ED patients. **Rate of infection per 10,000 patient days.**	Through Dec 2021	17	2.67	25%	**0.67**	19	1.87	25%	**0.47**	14	1.57	25%	**0.39**
2	**SSI**	NHSN/CDC	Number of SSI per **total # surgical procedures x 100**	Through Dec 2021	17	0.31	25%	**0.08**	22	0.31	25%	**0.08**	23	0.35	25%	**0.09**
3	**Inpatient Unit Patient Falls**	NDNQI/Press Ganey	Patient falls reported to NDNQI **per 1000 Patient Days (NDNQI reported)**. Excludes ED, L&D and intentional falls.	Through Jan 2022	175	2.25	15%	**0.34**	195	2.28	15%	**0.34**	196	1.45	15%	**0.22**
4	**HAPI**	NDNQI/Press Ganey	Stage 3, Stage 4 and Unstageable Hospital Acquired Pressure Injury Rate (excludes skin failure and expired patients). **Per 1000 Total Patient Days**	Through Jan 2022	4	0.05	20%	**0.01**	6	0.06	20%	**0.01**	10	0.11	20%	**0.02**
5	**NV HAP**	Internal measure	number of nvHAP cases per **1000 patient days**	Through Feb 2022	79	1.16	15%	**0.17**	55	0.59	15%	**0.09**	121	1.31	15%	**0.20**
ECH HAC INDEX					**0.25**				**0.20**				**0.18**			

Target	Improvement from FY22 baseline
Threshold	5%
Target	7.50%
Max	10%

El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Vince Manoogian, Interim President ECHMN, and Ute Burness, RN, VP of Quality, ECHMN
Date: April 20, 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 outpatient 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 (Merit Based 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 the 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 Q3 is a composite score of 3.3, which is a decrease from the previous 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 retrained the staff. We have been doing some chart abstraction. We also have updated the colorectal cancer screening protocol. We are meeting with all of the providers and staff to discuss the importance of quality. We have hired a clinical educator and have developed a MA training and work flow process that is being implemented in FY22 4th quarter. We are working on implementing the EPIC “Hedis Module” for our fully capitated health plans. We anticipate going live 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 March was 77.5,, which is above 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.

5. ECHMN has approved 17 initial appointments and 37 reappointments during the 2nd quarter.

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

El Camino Health Quality Committee Meeting

Vince Manoogian, CMPE, Interim President, ECHMN
Ute Burness, RN, VP Quality, ECHMN

May 2, 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 Q3

- Cancer screening measures have been a struggle nationally due to patients not getting tested during COVID.
- 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.

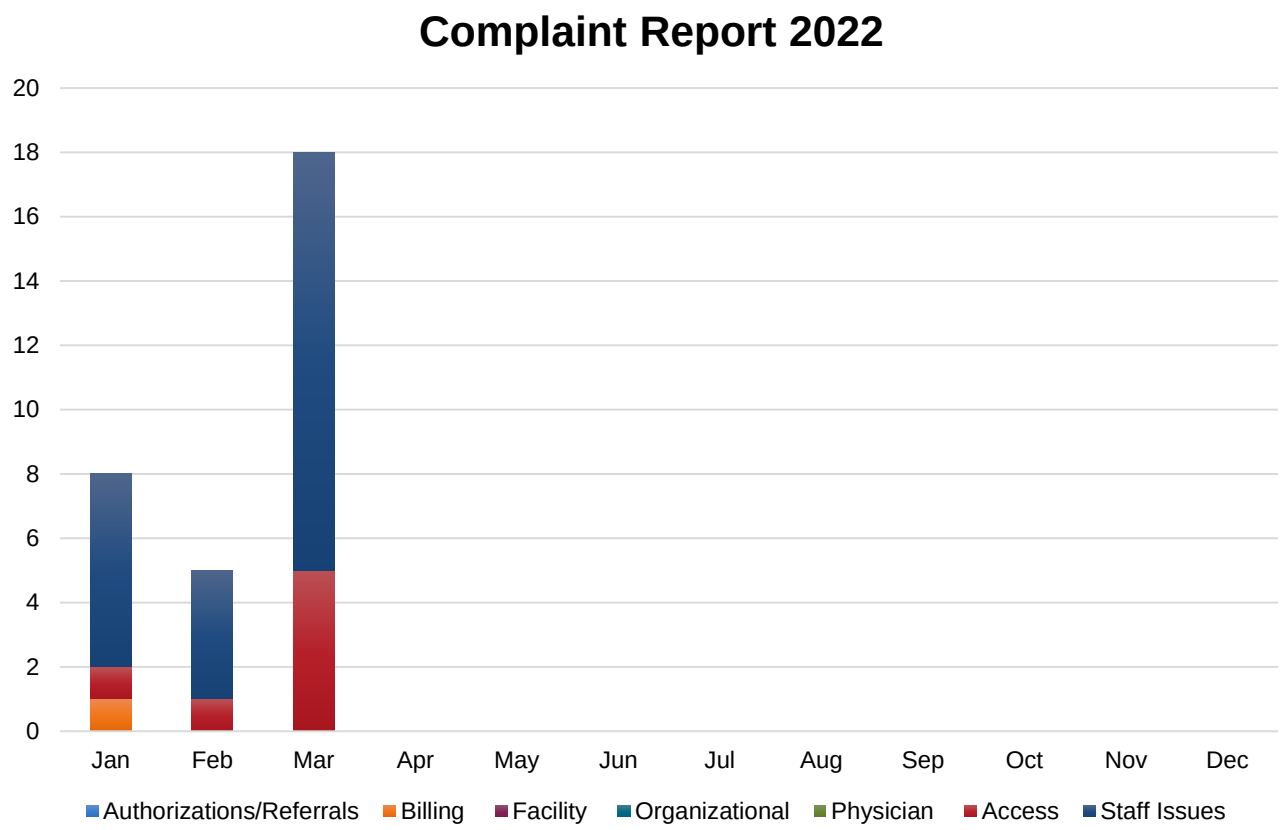
Metric	FY22 Second Qtr. Performance	FY22 Third Qtr. Performance	Performance from Previous Qtr.
Composite Score	**3.5**	**3.3**	**Decrease**
CMS 68- Documentation of Current Meds	97%	96%	Decrease
CMS 69- Prevention and Screening Body Mass Index – Screening and Follow Up Plan	58%	59%	Improvement
CMS 122- Diabetes: Hemoglobin A1C Poor Control (lower % is better)	24%	47%	Decrease
CMS 125- Breast Cancer Screening	63%	57%	Decrease
CMS 130- Colorectal Cancer Screening	47%	47%	Same
CMS 138- Tobacco Screening and Counseling	97%	95%	Decrease
CMS 139- Fall Risk Screening	91%	85%	Decrease
CMS 165- Controlling Blood Pressure	59%	56%	Decrease

Quality Improvement Activities – 3rd Quarter FY22

Topic	Description
Urgent Care	Met with Vituity and Willow Glen urgent care providers to discuss an action plan for improvement
Medical Assistants	Refresher course offered to all MA's. Developing and implementing MA standard workflow and accountability. MA competency assessments. Implementing a MA rooming checklist.
Breast Cancer and Colorectal Cancer Screening	Performing chart abstraction (we have limited resources) to clear false care gaps. There are some capacity issues with mammograms and referrals to GI department.
Colorectal Cancer Screening Protocols	Met with Dr. Savur to discuss updating the PCP protocols for Colorectal cancer screening. New protocols to be approved by the quality committee and then sent out to PCP's.
AWV Visits for Managed Care Plans	Roughly 2000 patients that need AWV this year. Rosters sent to the practice managers to schedule the visits.
HBA1C	Diabetic patient report to be sent to the PCP's so that they can order the test

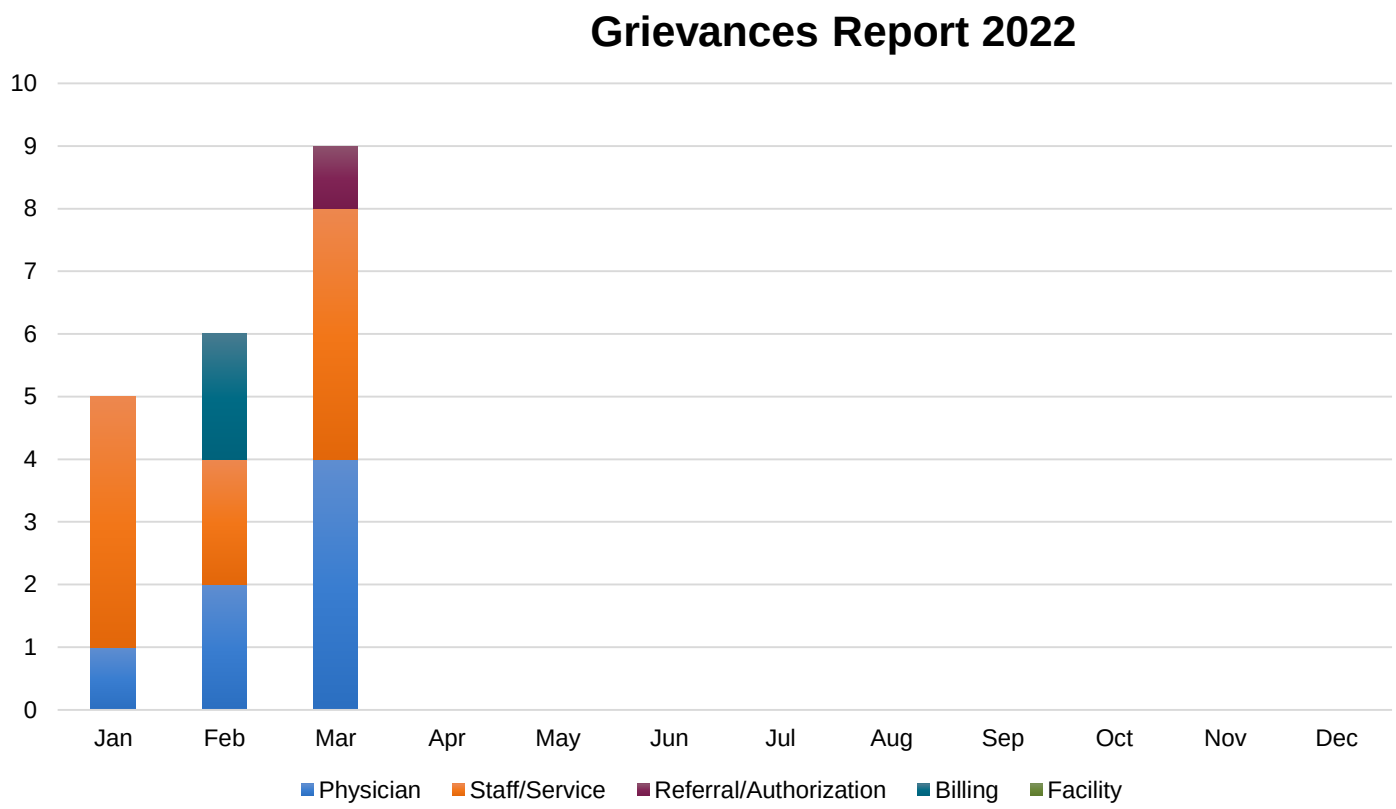
2022 Complaints Year to Date through March 31, 2022

- Complaints spiked in the month of March.
- The majority of the complaints were about the Sobrato location not responding to their messages and phone call.
- All complaints are based on the patients perception and all complaints are investigated.
- Complaints are shared with management at the various departments, so that they are aware and if changes are necessary, changes can be made.



2022 Grievances Year to Date through March 31, 2022

- Grievances increased in March.
- Grievances are written complaints that member typically report to their health plan.
- 8 out of the 9 grievances were about issues with staff and physicans.
- Grievances are based on the patient's perception and all grievances are investigated.
- 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

FY23 SVMD Quality Metrics Proposal

FY23 Quality Metrics and Targets

- Subcommittee
  - Dr. Iyengar, Dr. Husain, Dr. Ornelas, Ute Burness, RN and Vince Manoogian
- Subcommittee met on March 23, March 30, April 6, April 15 to review suggested metrics
- SVMD Quality Committee met on April 7th to review and approve the recommendations
- SVMD Board of Managers on April 19th
- ECH System Quality committee presentation on May 1st

Subcommittee Recommendations

- Two (2) dashboards, one for the PCPs and one for the Specialists
- PCP Dashboard will include the following:
  - The PCP measures will be based on patients seen by the Primary Care Physicians (PCP's)
  - PCP includes Family Medicine, Internal Medicine Physicians and Allied Health Professionals (AHP) who work in primary care
  - 10 quality measures have been selected, each measure will have a threshold
  - The measures are CMS and/or HEDIS measures
  - The thresholds are based on showing improvement year over year for each measure
- Specialty Dashboard will include the following:
  - 5 quality measures have been selected, each measure will have a threshold
  - The measures are CMS and/or HEDIS measures
  - The thresholds are based on showing improvement year over year for each measure

FY23 Proposed PCP Quality Metrics

CMS Measure #	Metric Description
68	Medication Reconciliation
69	BMI Screening and Follow up Action Plan
122	Diabetes: HbA1C Control
125	Breast Cancer Screening
130	Colorectal Cancer Screening
131	Diabetes: Diabetic Eye Exam
134	Diabetes: Kidney Disease Function
139	Fall Risk Screening
147	Annual Flu Vaccination
165	Controlling Blood Pressure

FY23 Proposed Specialty Metrics

CMS Number	Measure Description
68	Medication Reconciliation
69	BMI Screening and Treatment Plan
139	Fall Risk Screening
165	Controlling Blood Pressure
122 or 131 or 134	Diabetes Measure- must do one the measures, HbA1C, eye exam or kidney monitoring

Appendix

CMS 68 – Documentation of Current Medications in the Medical Record

- **Description:** Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.
- **FY 22 Target:** 91% (5th decile, 3 points)
- **3rd Qtr FY 22 Performance:** 96% (5th decile, 3 points)
- **2nd Qtr FY 22 Performance:** 97% (6th decile, 3 points)
- **1st Qtr FY 22 Performance:** 98% (7th decile, 4 points)
- **FY 22 Improvement Activities:**
  - *"Hard stop" has been implemented within EPIC*
  - *Staff received are refresher course on the quality measures*

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

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

- **Description:** Percentage of patients aged 18 and older with a BMI documented within the current encounter or during the previous 12 months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous 12 months of the current encounter. Normal parameters: =>18.5 and <25 kg/m2

- **FY 22 Target:** 53% (6th decile, 3 points)
- **3rd Qtr FY 22 Performance:** 59% (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*
  - *Staff received a refresher course on the quality metrics*
  - *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.
-
- **FY 22 Target:** <29%(10th decile, 5 points)
- **3rd Qtr FY 22 Performance:** 47% (7th decile, 4 points)
- **2nd Qtr FY 22 Peformance:** 24% (10th decile, 5 points)
- **1st Qtr FY 22 Performance:** 27% (10th decile, 5 points)
- **FY 22 Improvement Activities:**
  - *List of patients with overdue HBa1C tests were sent to all PCP's*
  - *List of patients whose HBa1c is not controlled sent to the PCP's*

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

- **FY 22 Target:** 55% (6th decile,3 points)
- **3rd Qtr FY 22 Performance:** 57% (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:**
  - *Chart Abstraction to reconcile the charts and close false care gaps*
  - *List of patients needing mammograms sent to the PCP's*

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 22 Target:** 45% (5th decile, 3 points)
- **3rd Qtr FY 22 Performance:** 47% (6th decile, 3 points)
- **2nd Qtr FY 22 Performance:** 48% (6th decile, 3 points)
- **1st Qtr FY 22 Performance:** 45% (5th decile, 3 points)
- **FY 22 Improvement Activities:**
  - *List of patients that need colorectal cancer screening sent to PCP's*
  - *Colorectal cancer screening protocols updated and sent to PCP's*
  - *Training of staff on process of ordering FOBT and Cologuard*

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

- **FY 22 Target:** 94% (7th decile, 4 points)
- **3rd Qtr FY 22 Performance:** 95% (7th decile, 4 points)
- **2nd Qtr FY 22 Performance**: 97% (8th decile, 4 points)
- **1st Qtr FY 22 Performance:** 96% (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*
  - *Providers need to screen for tobacco use and document 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

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 22 Target:** 83% (6th decile, 3 points)
- **3rd Qtr FY 22 Performance:** 85% (6th decile, 3 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:**
  - *Staff have been retrained on doing the fall risk screening*

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 22 Target:** 57% (6th decile, 3 points)
- **3rd Qtr Performance:** 56% (6th decile, 3 points)
- **2nd Qtr Performance**: 59% (6th decile, 3 points)
- **1st Qtr Performance**: 60% (7th decile, 4 points)
- **FY 22 Improvement Activities:**
  - *Retraining of all staff and providers on retaking the blood pressure at the end of the visit if the Blood Pressure is high at the start of the visit*
  - *Consider having a blood pressure clinic*

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

El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: May 2, 2022
Subject: Quarterly Board Quality Dashboard (STEEEP) FY22 Q3

Summary:

1. Situation: The Quarterly STEEEP Dashboard performance is reviewed by the Quality Committee preceding submission to the Board of Directors.

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: The STEEEP Quarterly Board Quality Dashboard is designed to provide the Board with a standardized high-level snapshot of overall quality and safety. Some measures, by their nature, are lagging such as readmissions and the obstetrical metrics. Results on the attached dashboard are through March FY22 unless annotated with an asterix *. This dashboard is based on the STEEEP framework of quality and safety that is a national standard adopted by the Institute for Healthcare Improvement (IHI).

4. Assessment: The Board Quality Committee will continue to review the more detailed monthly dashboard, which includes control charts and detailed analysis of topics. The Board will rely on this STEEEP dashboard for a governance level assessment of quality, safety and patient experience performance. Described below are areas with opportunity for improvement and select areas of success.

A. Safe Care:

i. Catheter Associated Urinary Tract Infection (CAUTI) – HAI. The FY22 target for CAUTI is ≤ 0.75. Our FY22 TD performance is 0.76. We have sustained improvement (no CAUTIs) from FY22Q1 when there were several CAUTIs in our CCU unit. As a result of the focused education and retraining, this unit has not had a patient experience a CAUTI for **225 days**. The enterprise has been CAUTI-free for **106 days**.

ii. Central Line Associated Blood Stream Infection (CLABSI) – HAI. The FY22 target for CLABSI rate is ≤ 0.50. Our FY22 YTD performance is 0.43. There has been an uptick in CLABSI this quarter. There were was 1 CLABSI in February (CCU) and 2 in March (1 PCU, 1 4B). Three CLABSI in the 3rd quarter translates to a rate of 0.88. Historically we had two CLABSI in FY20 and 6 CLABSI in FY2021.

iii. Modified PSI-90 CMS HAC Reduction Program (composite). The FY22 target for this metric is 0.90. Our FY22YTD performance is 0.899. We had eight safety events in the third quarter that affected an increase (unfavorable) in our performance (1.098 in Q3). The PSI-90 Composite is based on 10 safety measures;

1. **Pressure ulcer**
2. **Iatrogenic pneumothorax**
3. Fall with hip fracture
4. Perioperative hemorrhage or hematoma
5. Post op kidney injury requiring dialysis
6. Post op respiratory failure
7. **Perioperative DVT or PE**
8. **Postop sepsis**
9. Postop wound dehiscence
10. **Unrecognized abdominopelvic accidental puncture or laceration**

The eight events our patients experienced in the third quarter are; 1 pressure ulcer, 1 iatrogenic pneumothorax, 3 perioperative DVT or PE, 1 postop sepsis and 2 unrecognized abdominopelvic accidental puncture or laceration.

B. Timely:

i. Patient throughput – Median Time Arrival to ED Departure. FY22 target is 256 minutes. FY22 YTD is 288 minutes. The surge of Omicron affected the volume and complexity of patients in the ED in January and February. Radiology turnaround times for ED patients increased during these same months, for the same reasons, which in turn increases the amount of time needed for evaluation and care for ED patients. Because of both of these factors, the ED throughput times increased on both campuses. This remains an area of focus for management. One of several countermeasures includes a focus on early discharge of inpatients to increase capacity, which decreases need for patients to board in the ED.

C. Effective:

i. Risk Adjusted Readmission Index. The data for this measure is through January 2022. Our FY22 target is 0.92 and current FY22YTD is 1.03. The number of patients readmitted to ECH going back to 2016 has remained relatively stable. We readmit 100 patients per month, ± 10 patients. (Readmission Index Graphs Attachment--Graph 1) What has changed over time since 2016 is the complexity and acuity of our patients resulting in an increasing expected rate of readmission. (Readmission Index Graphs Attachment--Graph 2) ECH has actually performed better with our sicker patients and overall the O/E Readmission Index is improving (decreasing) over time. (Readmission Index Graphs Attachment--Graph 3)

ii. Elective Delivery Prior to 39 Weeks Gestation PC-01. This data shows only month of January of Q3. There was one induction in January with a denominator of 18 deliveries between 36+0 and 38+6 weeks. The rate is at 5.6% due to small denominator. If we continue on our trajectory, we can maintain our performance and be able to achieve our FY22 target of 1.3% rate.

iii. NTSV C-Section PC-02. The cesarean section rate has improved in the month of January with 34 cesarean sections performed out of 163 births resulting in a rate of 20.9% for the month helping us approach our FY22 target of 23.5%.

D. Patient Centered:

i. All inpatient metrics for likelihood to recommend increased in the third quarter and are at or above target. The ECHMN performance improved from 75.6 percent of patients with top box LTR in Q2 to 76.1 in Q3. The FY22 YTD performance for ECHMN is at 75.0 with a FY22 target of 77.4.

List of Attachments:

1. FY 2022 Q3 Quarterly Board Dashboard (STEEEP)
2. Readmission Index Graphs

El Camino Health

Month to Quality Committee of the Board: May 2022

Quarterly Board Quality Dashboard (STEEEP) FY22 end of March (unless otherwise specified by *)

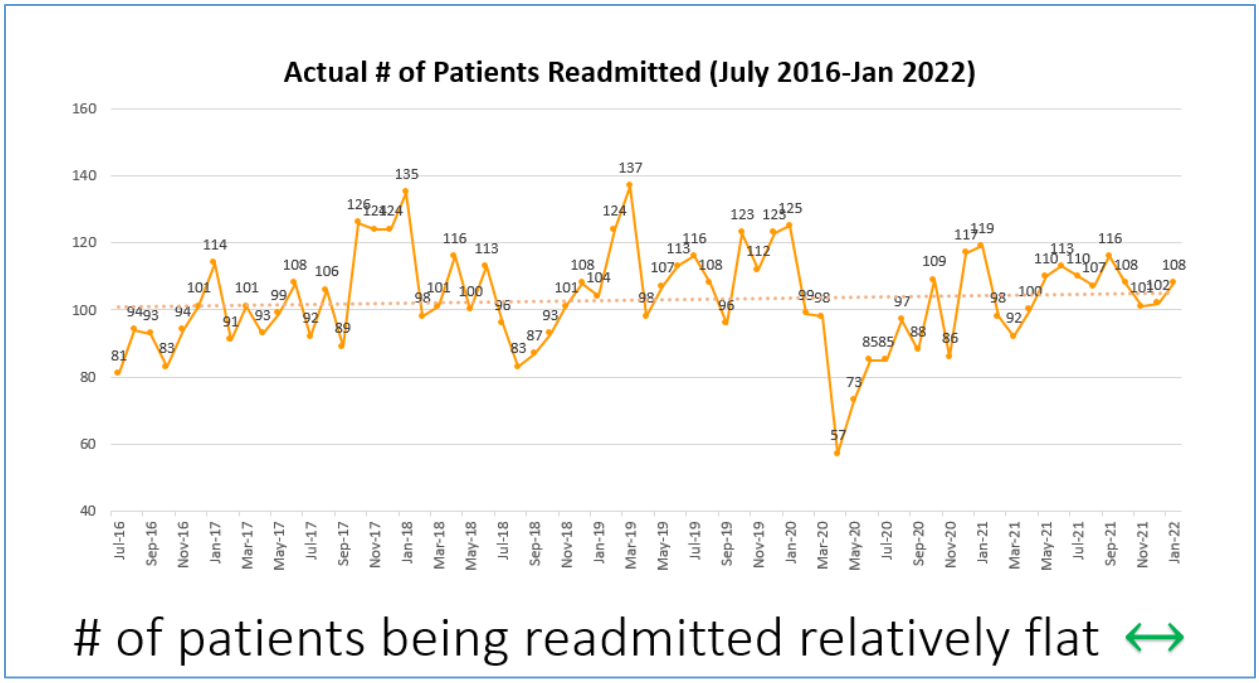
Quality Domain	Metric	Baseline	Target	Performance				
		FY 21	FY 22	FY22, Q1	FY22, Q2	FY22, Q3	FY22, Q4	FYTD22 Total
Safe Care	SSE (Serious Safety Events) Rate (Rolling 12 month)	3.13	2.97	2.44	2.59	*2.50		2.50
	Surgical Site Infections (SSI)	0.30	1.0 (SIR)	0.36	0.21	0.46		0.33
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	0.37	<= 0.75	1.32	0.81	0.29		0.76
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.53	<= 0.50	0.33	0.00	0.88		0.43
	Modified PSI-90 CMS HAC Reduction Program (composite)	0.919	0.90	0.846	0.873	1.098		0.899
Timely	HVI STEMI % 1st Medical Contact to Device Time w/I 90 minutes	100%	100%	100% (13/13)	100% (15/15)	Not available		100%
	Patient Throughput - Median Time Arrival to ED Departure	264 min	256 min	267 min	284 min	317 min		288 min
	Stroke: TTITT (time to intravenous thrombolytic therapy) <= 30 min	57.5% (14/23)	50%	25% (1/4)	10% (1/10)	Not Available		14.3%
	Stroke: Door-to-Groin <= 75 minutes	16.7% (3/18)	50%	50% (1/2)	14.3% (1/7)	Not Available		22.2%
	Stroke: Door-to-Groin <= 90 minutes	50% (9/18)	NA	50% (1/2)	28.6% (2/7)	Not Available		33.3%
Effective	Risk Adjusted Readmissions Index	0.93	0.92	1.07	0.96	*1.1		1.03
	Risk Adjusted Mortality Index	0.86	0.90	0.99	0.87	0.86		0.89
	Sepsis Mortality Index	1.08	1.03	1.06	0.97	1.03		1.02
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	ENT: 0.63%	1.3%	1.8%	1.2%	*5.6%		1.8%
	PC-02 NTSV C-Section	ENT: 26.3%	23.5%	25.8%	25.0%	*20.9%		24.8%
	ECHMN: CMS 165 Controlling High Blood Pressure	59.0%	>= 59%	60.0%	59.0%	56.0%		58.3%
	ECHMN: CMS 122 Diabetes Hemoglobin A1c Poor Control	30.0%	<= 30	24.0%	26.0%	48.0%		32.0%
Efficient	Arithmetic Observed LOS/ Geometric Expected LOS	1.29	1.30	1.35	1.33	1.40		1.36
	MSPB-1 Medicare Spending per Beneficiary (CMS)	0.99 (CY 19)	<=1	0.99	1.0 (CA: 1.0, NA: 0.99)	NA (updated annually, January)		0.99
Equitable	Hospital Charity Care Support	$19.7 mil	NA	$7.2 mil	$11.5 mil	$7.6 mil		$26.3 mil
	Clinic Charity Care Support	$14.9k	NA	$7.5k	$3.0k	$5.3k		$15.8k
	Language Line Unmet Requests	0.72%	<1%	0.62%	0.36%	0.15%		0.38%
	Length of Stay Disparity (Top 3 races) 40% patients did not report their race	Black: 4.0	NA	4.3	4.03	4.01		4.11
		White: 3.89		3.77	3.88	4.20		3.95
		Asian: 3.57		3.59	3.67	3.67		3.64
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	79.6	79.7	82.0	80.2	82.1		81.3
	ED - Likelihood to Recommend (PG)	76.1	76.5	73.1	75.7	77.2		75.5
	ECHMN - Likelihood to Recommend Care Provider (NPS)	76.0	77.4	74.1	75.6	76.1		75.0
	MCH - HCAHPS Likelihood to Recommend	81.8	82.0	79.4	80.5	82.1		80.8
	OAS - HCAHPS Likelihood to Recommend	85.7	86.1	85.5	87.6	86.8		86.6

Updated: 4/22/2022

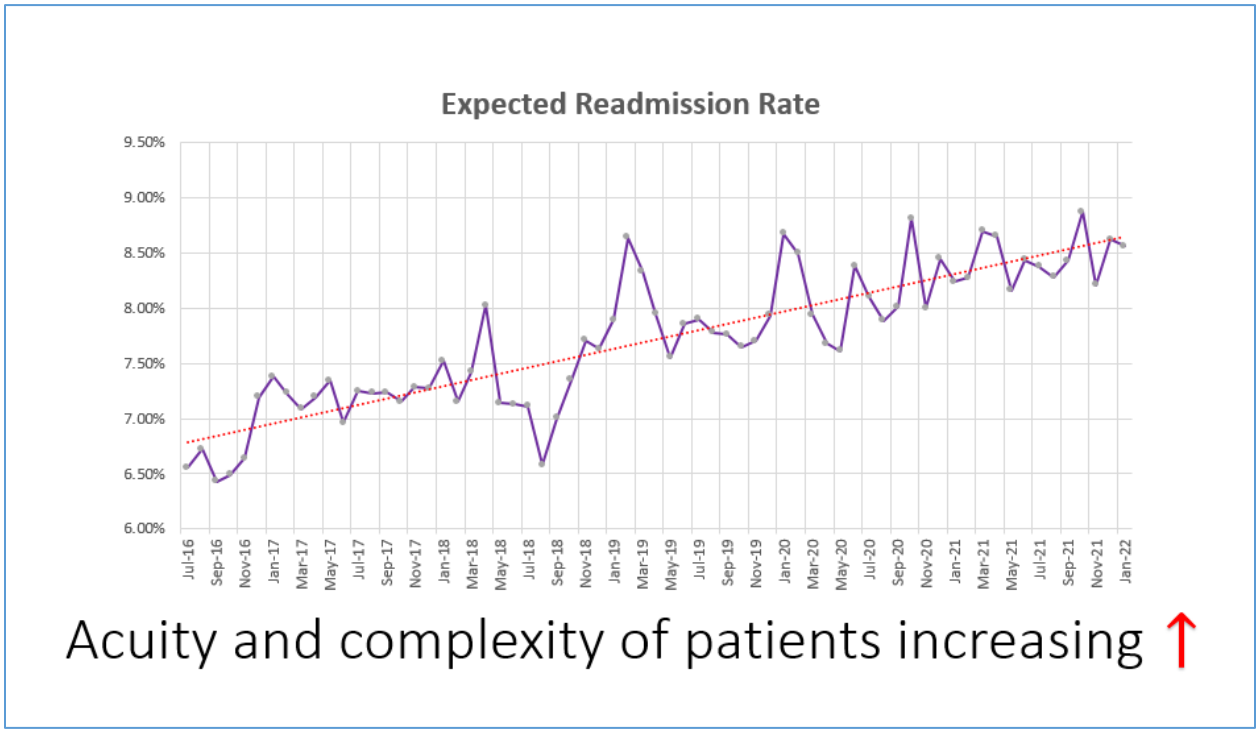
STEEEP: Safe Care, Timely, Effective, Efficient, Equitable, Patient-Centered

Attachment: Readmission Index Graphs

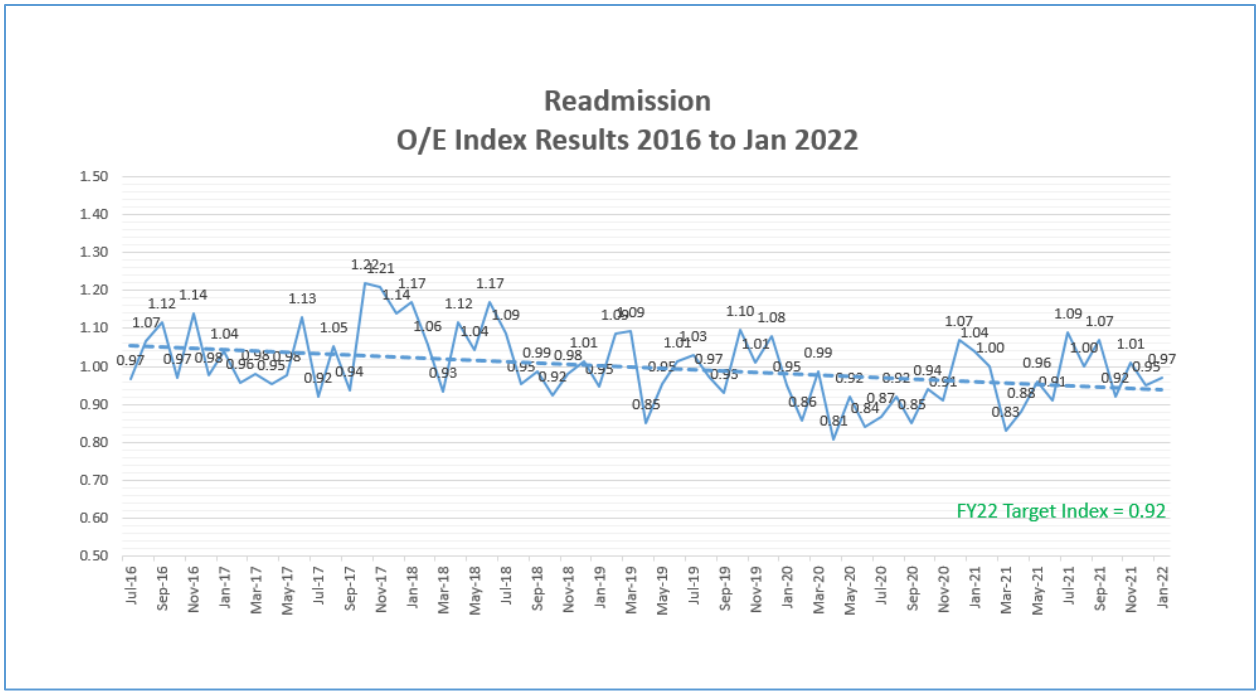
Graph 1



Graph 2



Graph 3


Readmission
O/E Index Results 2016 to Jan 2022
1.50
1.40
1.30
1.20
1.10
1.00
0.90
0.80
0.70
0.60
0.50
FY22 Target Index = 0.92
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19
Nov-19
Jan-20
Mar-20
May-20
Jul-20
Sep-20
Nov-20
Jan-21
Mar-21
May-21
Jul-21
Sep-21
Nov-21
Jan-22