El Camino Health

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

**Monday, August 1, 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: 989 8998 3983#. No participant code. Just press #.**

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

| | AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
|---|---|---|---|---|
| 1. | **CALL TO ORDER/ROLL CALL** | Carol Somersille, MD<br>Quality Committee Chair | | **5:30 – 5:33pm** |
| 2. | **POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Carol Somersille, MD<br>Quality Committee Chair | | **information**<br>**5:33 – 5:34** |
| 3. | **PUBLIC COMMUNICATION** | Carol Somersille, MD<br>Quality Committee Chair | | **information**<br>**5:34 – 5:37** |
| 4. | **CONSENT CALENDAR ITEMS**<br>*Any Committee Member or member of the public may pull an item for discussion before a motion is made.* | Carol Somersille, MD<br>Quality Committee Chair | *public comment* | **motion required**<br>**5:37 – 5:47** |
| | ***Approval***<br>a. Minutes of the Open Session of the Quality Committee Meeting (06/06/2022)<br>***Information***<br>b. Report on Board Actions<br>c. FY 23 Pacing Plan<br>d. FY 23 Enterprise Quality Dashboard<br>e. QC Follow-Up Items | | | |
| 5. | **CHAIR'S REPORT** | Carol Somersille, MD<br>Quality Committee Chair | | **information**<br>**5:47 – 5:57** |
| 6. | **QUALITY COMMITTEE MEMBER RECRUITMENT** | Carol Somersille, MD<br>Quality Committee Chair | | **discussion**<br>**5:57 – 6:07** |
| 7. | **AD HOC COMMITTEE RECRUITMENT FORMATION** | Carol Somersille, MD<br>Quality Committee Chair | *public comment* | **possible motion**<br>**6:07 – 6:12** |
| 8. | **PATIENT STORY** | Cheryl Reinking, DNP, RN NEA-BC,<br>Chief Nursing Officer | | **discussion**<br>**6:12 - 6:22** |
| 9. | **HEALTH CARE EQUITY** | Holly Beeman, MD, MBA,<br>Chief Quality Officer | | **discussion**<br>**6:22 – 6:32** |

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

| | AGENDA ITEM | PRESENTED BY | | ESTIMATED TIMES |
|---|---|---|---|---|
| **10.** | **Q4 FY22 STEEEP DASHBOARD REVIEW** | Holly Beeman, MD, MBA, Chief Quality Officer | | **discussion 6:32 – 6:47** |
| **11.** | **EL CAMINO HEALTH MEDICAL NETWORK REPORT** | Shahab Dadjou, Interim President, El Camino Health Medical Network<br>Ute Burness, VP of Quality and Payer Relations | | **discussion 6:47 – 7:02** |
| **12.** | **ADJOURN TO CLOSED SESSION** | Carol Somersille, MD Quality Committee Chair | *public comment* | **motion required 7:02 – 7:03** |
| **13.** | **POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Carol Somersille, MD Quality Committee Chair | | **information 7:03 – 7:04** |
| **14.** | **CONSENT CALENDAR**<br>*Any Committee Member may pull an item for discussion before a motion is made.*<br>***Approval***<br>*Gov't Code Section 54957.2.*<br>a. Minutes of the Closed Session of the Quality Committee Meeting (06/06/2022)<br>b. Quality Council Minutes (06/01/2022) | Carol Somersille, MD Quality Committee Chair | | **motion required 7:04 – 7:09** |
| **15.** | *Health and Safety Code Section 32155* **Q4 FY22 QUARTERLY QUALITY AND SAFETY REVIEW OF REPORTABLE EVENTS** | Holly Beeman, MD, MBA, Chief Quality Officer | | **discussion 7:09 – 7:19** |
| **16.** | *Health and Safety Code Section 32155* **CREDENTIALING AND PRIVILEGES REPORT** | Mark Adams, MD, Chief Medical Officer | | **motion required 7:19 – 7:29** |
| **17.** | *Health and Safety Code Section 32155* **SERIOUS SAFETY/RED ALERT EVENT** | Holly Beeman, MD, MBA, Chief Quality Officer | | **discussion 7:29 – 7:34** |
| **18.** | **ADJOURN TO OPEN SESSION** | Carol Somersille, MD Quality Committee Chair | | **motion required 7:34 - 7:35** |
| **19.** | **RECONVENE OPEN SESSION/ REPORT OUT**<br>To report any required disclosures regarding permissible actions taken during Closed Session. | Carol Somersille, MD Quality Committee Chair | | **information 7:35– 7:36** |
| **20.** | **CLOSING WRAP UP** | Carol Somersille, MD Quality Committee Chair | | **discussion 7:36 – 7:39** |
| **21.** | **ADJOURNMENT** | Carol Somersille, MD Quality Committee Chair | *public comment* | **motion required 7:39– 7:40 pm** |

**Next Meeting:** September 6, 2022, November 7, 2022, December 5, 2022, February 6, 2023, March 6, 2023, April 3, 2023, May 1, 2023, June 5, 2023

**Minutes of the Open Session of the**
**Quality, Patient Care and Patient Experience Committee**
**of the El Camino Hospital Board of Directors**
**Monday, June 6, 2022**
**El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040**

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

**via teleconference

| Agenda Item | Comments/Discussion | Approvals/ Action |
|---|---|---|
| **1. CALL TO ORDER/ ROLL CALL** | The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order at 5:33 pm by Vice Chair George Ting. A verbal roll call was taken. Dr. Burn and Chair Kliger were absent. Dr. Kan joined at 5:48 pm. All other members were present at roll call and participated in-person or telephonically. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020. | |
| **2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Vice Chair Ting asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported. | |
| **3. PUBLIC COMMUNICATION** | There were no comments from the public. | |
| **4. CONSENT CALENDAR** | Vice Chair Ting asked if any Committee member would like to pull an item from the consent calendar.<br><br>Dr. Somersille requested to pull items 4d - FY22 Enterprise Quality Dashboard and 4e – FY23 Committee Planning for discussion.<br><br>For 4d – FY 22 Enterprise Quality Dashboard, Dr. Somersille referenced page 14, likelihood to recommend care provider, and asked what is the average of this metric. Dr. Beeman shared that she can look into this and report back at the next meeting.<br><br>For 4e – FY 23 Committee Planning, Dr. Somersille referenced the pacing plan on pages 21-22, requesting to add Health Equity as a topic in June 2023 so planning can occur for the next fiscal year. Ms. Simon and Dr. Beeman agreed.<br><br>Dr. Po requested that a memo be included with the Enterprise Quality Dashboard explaining some of the movement that has | ***Consent Calendar approved*** |

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| | occurred, specifically the Readmission Index. He shared that in the past, a memo has typically been included. Dr. Beeman acknowledged and confirmed a memo will be included going forward.<br><br>**Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (05/02/2022) with the notated update; For information: (b) Report on Board Actions, (c) FY 22 Pacing Plan, (d) FY 22 Enterprise Quality Dashboard (e) FY 23 Committee Planning (Pacing Plan, Committee dates, Charter) (f) QC Follow-Up items<br><br>**Movant**: Somersille<br>**Second**: Po<br>**Ayes**: Marfatia, Po, Sharma, Somersille, Ting, Falwell, Simon<br>**Noes**: None<br>**Abstain**: None<br>**Absent**: Burn, Kan, Kliger<br>**Recused**: None | |
| **5. CHAIR'S REPORT** | Vice Chair Ting debriefed on last month's Hospital Board meeting on May 11, 2022, and highlighted the following:<br>• Dan presented the Strategic Goals<br>• Carlos presented the Quarterly Financials<br>• Special Recognition was given to Judy Van Dyke, who volunteered with the hospital for over 60 years<br>• Jon Cowan presented the Community Health needs assessment<br><br>Dr. Beeman introduced Shahab Dadjou, Interim President, ECHMN to the Committee. | |
| **6. PATIENT STORY** | Cheryl Reinking, CNO presented a Press Ganey comment received by a patient who recently delivered a baby at the Mountain View Campus. The patient shared that the bathroom in the delivery room appeared dirty and the paint was chipped at the base of the tub The patient commented that the bathroom ventilation was not good. Cheryl shared that while the renovation project of the MCH will address the concerns expressed by this patient, we must continue to assure the environment of care is safe, comfortable, and clean. The bathtub replacement and the new HVAC system for the building along with all the other upgrades will create an environment of care where families will feel comfortable and safe. After sharing this concern with our EVS staff, a note will be left next to the labor tub from the EVS staff after each cleaning indicating the tub has been cleaned thoroughly. | |
| **7. HRO JOURNEY UPDATE** | Dr. Mark Adams, CMO presented the HRO Journey update and highlighted the following:<br>• High Reliability Organization definition and examples<br>• Anatomy of a Proximate Cause<br>• Anatomy of a Safety Event | |

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| | • Human Error Classification<br>• Common Causes of Harm at El Camino Hospital<br>• Culture of Safety<br>• Six Key Success Factors<br>• Cause Analysis Workgroup<br>• Universal Skill Training<br>• Health Safety KPI Scorecard<br>• Branding for HRO | |
| **8. LEAPFROG** | Lyn Garrett, Senior Director, Quality presented on the Spring Leapfrog safety grades and highlighted the following:<br><br>• A brief background of Leapfrog and Grades<br>• Our current grade for Los Gatos is Grade B. Factors that impacted the lower grade, which was previously A, are (1) The enterprise-wide patient experience scores and (2) Two serious safety events at LG during the measurement time period. There was one central line-associated bloodstream infection (CLABSI) and one surgical site infection.<br>• Our current grade for Mountain view is Grade A<br><br>Dr. Mallur shared that Los Gatos is focused on getting back to a grade A. He shared a couple of things impacting this:<br><br>• 24/7 Intensive In-house coverage is required. Pharmacy rounds in the ICU is something Los Gatos is working on.<br>• Lower patient experience (HCAHPS) scores are enterprise-wide, not specific to Los Gatos<br><br>Dr. Kan shared that this was the first CLABSI in 3-4 years at Los Gatos. | |
| **9. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN** | Dr. Holly Beeman, CQO presented the Quality Assessment and Performance Improvement Plan and highlighted the following:<br><br>• This plan is revised annually<br>• This plan is required by CMS as a condition of participation, and, is reviewed in detail by The Joint Commission during on site accreditation surveys.<br><br>Ms. Simon noted that this is a CMS requirement and noticed this is hospital focused. She asked if we are planning to incorporate ECHMN or Ambulatory?<br><br>Dr. Beeman shared that this document and the contents there of is very specifically codified by the federal government. A QAPI plan describes acute care quality and experience plans, and, specifically does not describe other elements of a health care enterprise such as outpatient clinic visits in a foundation or medical group. | ***Quality Assessment and Improvement Plan approved*** |

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| | Further discussion and agreement by committee members to ensure the plans around quality and performance are also spelled out in a document for the ambulatory enterprise is important for ECH particularly as we focus on being an 'enterprise'.<br><br>**Motion**: To recommend to the Board the Quality Assessment and Performance Improvement Plan<br><br>**Movant**: Simon<br>**Second**: Somersille<br>**Ayes**: Kan, Marfatia, Po, Sharma, Somersille, Ting, Falwell, Simon<br>**Noes**: None<br>**Abstain**: None<br>**Absent**: Burn, Kliger<br>**Recused**: None | |
| **10. FY 23 ORGANIZATIONAL GOALS** | Dr. Holly Beeman, CQO presented the FY 23 Organizational Goals and highlighted the following:<br><br>Quality and Safety Pillar—Hospital Acquired Condition Index<br><br>• The HAC (Hospital Acquired Condition) Index includes: C. difficile infection, Surgical Site Infections (SSI), non-ventilator hospital-acquired pneumonia (nvHAP), hospital-acquired pressure injuries (HAPI) and patient falls<br>For the HAC Index, the methodology of combining disparate metrics to create a singular index is modeled on the CMS methodology for calculating a hospital's star rating based on a multitude of various performance measures.<br>Service Pillar-Likelihood to Recommend (LTR)<br><br>• Survey regarding Patient Experience for In-Patient and the Medical Network – Likelihood to recommend<br>• Target will be FY21 baseline plus a calculated improvement score from the top 50th percentile of improving organizations utilizing Press Ganey's proprietary goal calculator.<br><br>People Pillar-Culture of Safety Survey Results<br><br>• Managers – improvement in performance. Score above 4<br>• Employees – improvement of participation. Get % above 85%<br><br>Ms. Simon asked what the rationale is behind not having Re-admissions and SSE included in the HAC. Dr. Beeman shared that these items will be tracked closely. They will remain on the Enterprise Dashboard and the STEEEP Dashboard. These will not be an incentive performance goal but they will be a Strategic Goal.<br><br>**Motion**: To recommend to the Board the FY 23 Organizational Goals | ***FY 23 Organizational Goals approved*** |

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|---|---|---|
| | **Movant**: Kan<br>**Second**: Falwell<br>**Ayes**: Kan, Marfatia, Po, Sharma, Somersille, Ting, Falwell, Simon<br>**Noes**: None<br>**Abstain**: None<br>**Absent**: Burn, Kliger<br>**Recused**: None | |
| **11. ADJOURN TO CLOSED SESSION** | **Motion**: To adjourn to closed session at 7:06 pm.<br>**Movant**: Po<br>**Second**: Kan<br>**Ayes**: Kan, Marfatia, Po, Sharma, Somersille, Ting, Falwell, Simon<br>**Noes**: None<br>**Abstain**: None<br>**Absent**: Burn, Kliger<br>**Recused**: None | ***Adjourned to closed session at 7:06 pm*** |
| **12. AGENDA ITEM 18: RECONVENE OPEN SESSION/REPORT OUT** | The open session reconvened at 7:31 pm. Agenda items 12-17 were addressed in closed session.<br>During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (05/02/2022), the Quality Council Minutes (05/04/2022), and the Medical Staff Credentialing and Privileges Report by unanimous vote by all committee members present. | |
| **13. AGENDA ITEM 19: CLOSING WRAP UP** | Dr. Kan expressed his gratitude for his time on the Quality Committee. This is Dr. Kan's and Dr. Marfatia's last meeting. | |
| **14. AGENDA ITEM 20: ADJOURNMENT** | **Motion**: To adjourn at 7:34 pm<br>**Movant**: Kan<br>**Second**: Simon<br>**Ayes**: Kan, Marfatia, Po, Sharma, Somersille, Ting, Falwell, Simon<br>**Noes**: None<br>**Abstain**: None<br>**Absent**: Burn, Kliger<br>**Recused**: None | ***Adjourned at 7:34 pm*** |

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George Ting, MD
Vice 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:** August 1, 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** | June 8, 2022 | - Board Officer Elections<br>  o Bob Rebitzer, Board Chair<br>  o Jack Po, Board Vice-Chair<br>- FY23 Organizational Goals<br>- FY23 Master Calendar<br>- FY23 Committee Goals<br>- FY23 Committee Pacing Plans<br>- FY23 Committee and Liaisons Appointments<br>- Progress against FY22 Committee Goals<br>- Committee Charter Updates<br>- Employee Recognition<br>- Credentialing and Privileges Report<br>- MV General Surgery Call Panel Renewal<br>- Enterprise Pathology Medical Director Renewal<br>- Enterprise Cancer Program Medical Director Renewal<br>- MV Cath Lab Medical Director Renewal<br>- MV Respiratory Care Services Medical Director Renewal<br>- MV Cardiac Rehab Medical Director Renewal |
| **ECHD Board** | - N/A | |
| **Executive Compensation Committee** | June 24, 2022 | - Proposed Salary Range Change and Base Salary Change for Chief Operating Officer<br>- Proposed Salary Range Change and Base Salary Change for Chief Growth Officer |

Report on Board Actions
August 1, 2022

| **Board/Committee** | **Meeting Date** | **Actions** (Approvals unless otherwise noted) |
|---|---|---|
| **Compliance and Audit Committee** | - N/A | |
| **Finance Committee** | - N/A | |

**List of Attachments:** None.

**Suggested Committee Discussion Questions:** None.

El Camino Health

# Quality, Patient Care, and Patient Experience Committee

| AGENDA ITEM | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN |
| **STANDING AGENDA ITEMS** | | | | | | | | | | | | |
| Consent Calendar[1] | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Patient Experience Story | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Serious Safety/Red Alert Event (as needed) | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Credentialing and Privileges Report | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| **SPECIAL AGENDA ITEMS – MEDICAL STAFF ITEMS** | | | | | | | | | | | | |
| Medical Staff Office Audit Report | | | | | ✓ | | | | | | | |
| Report on Medical Staff Peer Review Process | | | | | | ✓ | | | | | | |
| Medical Staff Credential Process | | | | | | | | | | | | ✓ |
| **SPECIAL AGENDA ITEMS – OTHER REPORTS** | | | | | | | | | | | | |
| Quality & Safety Review of reportable events | | ✓ | | | ✓ | | | ✓ | | | ✓ | |
| Board STEEP Dashboard Review | | ✓ | | | ✓ | | | ✓ | | | ✓ | |
| El Camino Health Medical Network Report | | ✓ | | | ✓ | | | ✓ | | | ✓ | |
| Patient Safety Report | | | ✓ | | | | | | | | | |
| Patient Experience (HCAHPS) | | | ✓ | | | | | | | | | |
| Health Care Equity | | ✓ | | | | | | | ✓ | | | ✓ |
| High-Reliability Progress | | | ✓ | | | | | | ✓ | | | |
| Culture of Safety Survey Results | | | | | ✓ | | | | | | | |
| Safety Report for the Environment of Care | | | | | ✓ | | | | | | | |
| Readmission Dashboard | | | | | | ✓ | | | | | | ✓ |
| PSI Report | | | | | | ✓ | | | | | | ✓ |
| Sepsis Mortality Goal/Target Discussion | | | | | | ✓ | | | | | | |
| Value Based Purchasing Report | | | | | | | | | | ✓ | | |
| Approve Quality Assessment & Performance Improvement Plan (QAPI) | | | | | | | | | | | | ✓ |
| **COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR** | | | | | | | | | | | | |
| Propose Committee Goals | | | | | | | | | | ✓ | | |
| Approve Committee Goals | | | | | | | | | | | ✓ | |
| Propose FY Committee Meeting dates | | | | | | | | | | ✓ | | |
| Approve FY Committee Meeting dates | | | | | | | | | | | ✓ | |
| Propose Organizational Goals | | | | | | | | | | ✓ | | |
| Finalize FY23 Organizational Goals | | | | | | | | | | | ✓ | |
| Propose Pacing Plan | | | | | | | | | | ✓ | | |
| Approve Pacing Plan | | | | | | | | | | | ✓ | |

1: Includes Approval of Minutes (Open & Closed), Current FY Enterprise Quality Dashboard, Med Staff Quality Council Minutes (Closed Session), Progress Against FY Committee goals (Quarterly), Current FY Pacing Plan (Quarterly), Report on Board Actions, QC Follow Up Items, ED Patient Satisfaction (Sept), CDI Dashboard (Semi-Annual), Core Measures (Semi-Annual), Leapfrog (June)

El Camino Health

**El Camino Health Board of Directors**
**Quality, Patient Care and Patient Experience Committee Memo**

**To:** Quality, Patient Care and Patient Experience Committee
**From:** Holly Beeman, MD, MBA, Chief Quality Officer
**Date:** August 1, 2022
**Subject:** Enterprise Quality, Safety and Experience Dashboard through June 2022

**Purpose:**

To update the Quality Committee on quality, safety and experience metrics and performance through June 2022 (unless otherwise noted) as demonstrated on the FY22 Enterprise Quality, Safety and Experience Dashboard.

**Summary:**

**1.** Situation: The Fiscal Year 2022 Enterprise Quality, Safety, and Experience dashboard is used throughout the organization to illustrate, track, and communicate a key set of metrics to align the quality, safety, and experience improvement work. These key metrics were selected based on a review of the organizational incentive goals, strategic goals, and areas of concern based on standardized benchmarks. These are not the only metrics that are tracked but represent the highest priority for the organization.

**A.** Provide the Committee with a snapshot of the FY 2022 metrics monthly with trends over time and compared to the actual results from FY2021 and the FY 2022 goals.

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

**3.** Background: At the beginning of each fiscal year, an assessment is completed to identify specific areas for quality/performance improvement. A subset of these areas are then prioritized and designated as leading indicators to be tracked universally throughout the organization so that all clinicians—physicians included—and support staff are aligned in the improvement activities. Measures that demonstrate sustained improvement are removed (but still tracked) and others added. This Committee selected these twelve (12) metrics for monthly review as they reflect the Hospital's FY 2022 Quality, Safety and Service Goals.

**4.** Assessment: Of the hundreds of performance measures tracked and actively managed, twelve measures are reported on the Enterprise Quality Dashboard. Of these twelve, five metrics, which are not meeting target will be described here.

**A.** Readmission Index—During the month of May, 130 patients were readmitted within 30 days of their prior hospitalization. The most common diagnosis/disease patients readmitted in May are; Cardiac (Heart failure, myocardial infarction and post cardiac surgery) (22 patients)

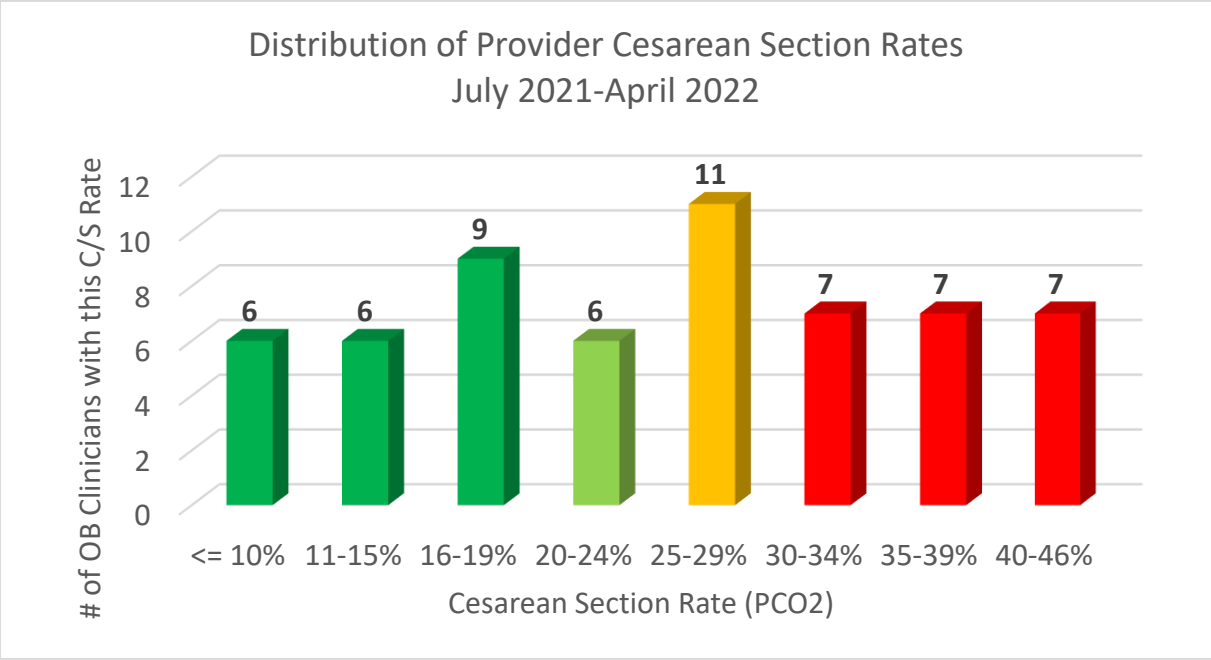
- Alcohol/Drug (19 patients)
- Complex patients (Diabetes, Cancer) (14 patients),
- Sepsis (12 patients)
- GI (bleed, obstruction) (8 patients)
- Respiratory (pneumonia, chronic obstructive pulmonary disease) (7 patients)

The observed rate of readmission was 9.47% in May compared to an expected rate of 8.62% resulting in an observed/expected readmission index of 1.10. Year to date through May of FY22 the readmission index is at 1.05 exceeding the target of an index of 0.92. A more detailed review of readmissions and the work underway to decrease the readmission index will be described in the STEEEP dashboard memo/agenda item for this committee meeting.

**B.** Emergency Department likelihood to recommend ECH (patient experience survey)—The FY22 target for top box rating of "yes definitely likely to recommend' (LTR) in the HCAHPS patient experience survey is 79.7%. Both the month (70.9%) and fiscal year to date performance (74.5%) did not meet target in FY2022. Trends in the bay area and California for ED patient experience performance saw similar decrease in patients' experiences. With our performance of 74.5% top box for LTR, the ECH EDs are at the 86$^{th}$ percentile in the Bay Area and 94$^{th}$ percentile in California. The patient experience team reports that the challenges of high volumes, staff shortages and boarding patients will continue into FY23, however, we have solid leadership in place and that will help. We continue to focus on patient flow, intercampus transfers, early discharge and patient communication

**C.** ECHMN MD likelihood to recommend care provider (patient experience survey)—The FY22 target for top box rating of "yes definitely likely to recommend care provider" is 77.4%. The month performance (66.8% top box) and year end performance for FY22 (74.5% top box) are below target and lower than FY21 performance (76.0%). As the scores for different practice types within ECHMN are evaluated, the lowest performing area is urgent care followed by primary care. The surgical and medical specialty departments are performing at goal. A solid plan is in place for FY23 with a focus on resiliency and recruitment of staff as well as establishing key improvement plans in low scoring clinics, focus on our primary care and urgent care clinics. The performance and improvement plans for these areas will be reviewed in more detail during the ECHMN Report agenda item for this committee meeting.

**D.** PCO2 Cesarean Birth (data through March 2022)—This metric tracks rate of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. The data for this measure is through March 2022. There has been a favorable decrease in cesarean section rate for FY22YTD (25.0%) compared to FY21 actual performance (26.30%). Current performance in latest month of March (25.7%) and for YTD (25%) is below the target for FY22 of 23.5%. A review of CMQCC data from July 2021 to April 2022 demonstrates that over half of providers have a c/s rate => 25%. After excluding 16 clinicians with <10 deliveries (of nulliparous woman with term, singleton baby in vertex position) in this time frame, the remaining 60 clinicians are analyzed with the following results; 32 clinicians had c/s rate=> 25% and 27 clinicians had c/s rate <= 24%. The problem of a high c/s rate (>25%) is distributed amongst more than half of the OB physicians (see graph: Distribution of Provider Cesarean Section Rates). Reducing the cesarean section rate for women having their first births is a strategic priority for maternal child health in FY23.




**E.** Emergency Department Throughput—The median time from arrival to ED departure remains longer than desired throughout FY2022. The enterprise target for FY22 is 256 minutes. Performance in June (307 minutes) and for FY22 (290 minutes) is adversely exceeds target. The Patient Throughput Value Stream for FY22 continues to focus on stabilizing the Capacity Management Center (CMC) and improving the discharge process. The discharge lounge is now staffed on weekdays from 8:30am – 5pm with a RN. We predict that will increase the in-patient units to discharge more patients by noon. Team Health continues to participate in afternoon multidisciplinary discharge rounds to help prepare for next day discharges. PAMF has agreed to add discharge planning to progress notes as a standard to improve communication and transparency across disciplines. Our executive team continues to Gemba and support the units by removing barriers to discharge by noon. Our nursing leaders continue to assist in our focus improving both discharge by noon and the electronic SBAR process

**List of Attachments**

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

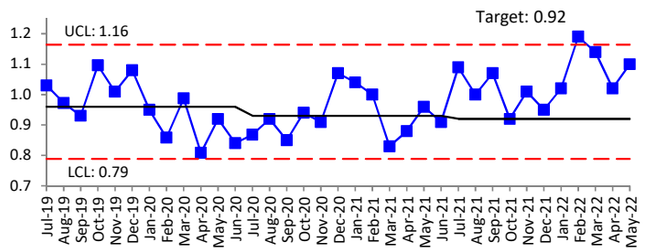
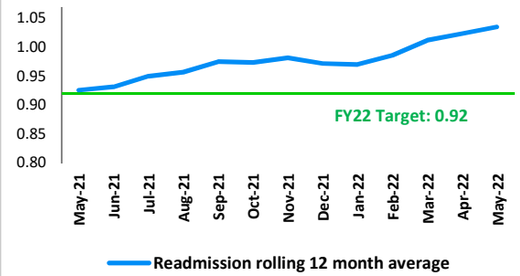
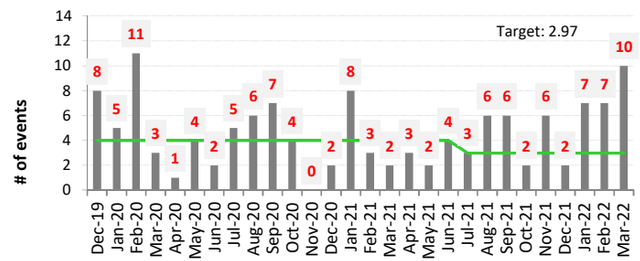
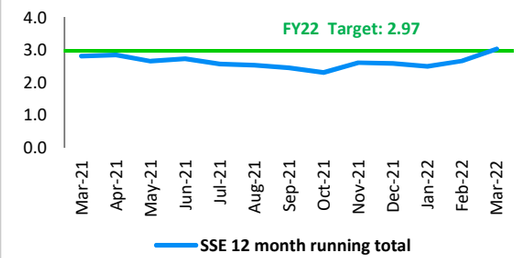
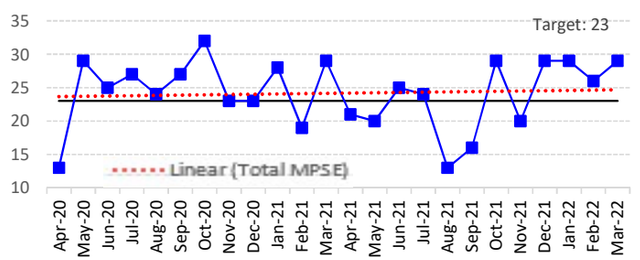
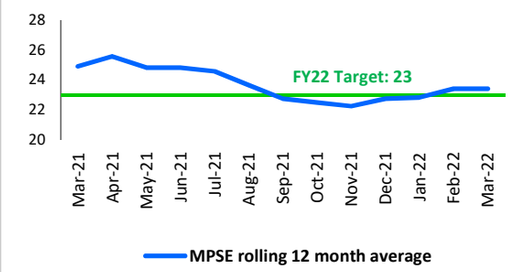
El Camino Health

# Enterprise Quality, Safety, and Experience Dashboard

**June 2022 (unless otherwise specified)**

**Month to Board Quality Committee:**

**August, 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**<br>**Readmission Index (All Patient All Cause Readmit) *Observed/ Expected***<br>***Premier Standard Risk Calculation Mode***<br>****Latest data month: May, '22* | 1.10<br>(9.47%/8.62%) | 1.05<br>(8.96%/8.56%) | 0.93 | 0.92 |  |  |
| 2 | ***Organizational Goal**<br>**Serious Safety Event Rate (SSER)**<br># of events/<br>FYTD rolling 12 month<br>per 10,000 Acute Adjusted Patient Days *Rate*<br>****Latest data month: Mar, '22* | 10 | 3.04<br>(58/190973) | 3.13<br>(Dec 2019 - Jun 2021) | 2.97 |  |  |
| 3 | **Actual # of Medication Precursor Safety Events (MPSE) per month/**<br>FYTD rolling 12 month average<br>****Latest data month: Mar, ' 22* | 29 | 23.4/ mo<br>(12 month rolling average) | 320<br>(25/month)<br>*(April 2020 to April 2021)* | 304<br>(23/month)<br>*(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).<br><br>*For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*<br>*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. **IMPORTANT: HAPIs classified as an SSE may differ from internally reported HAPIs d/t different criteria (SSE - reportable to CDPH).**<br><br>*For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*<br>*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<br>EPSI report used for Patient days and # of events provided by Deep M.<br><br>**Target data received from S. Shah 8/12/21 via email - 5% reduction from baseline** | iSafe Reports / EPSI Report / Safety Event Classification |

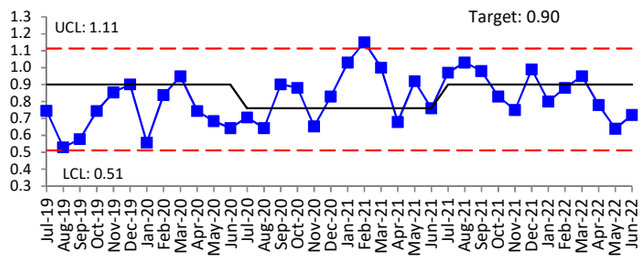
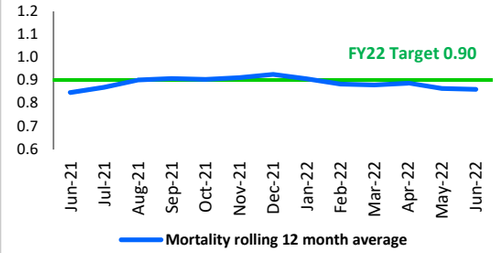
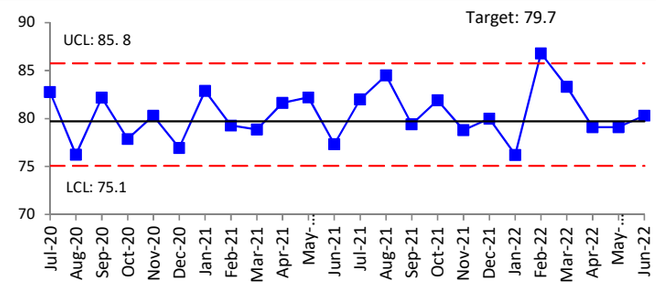
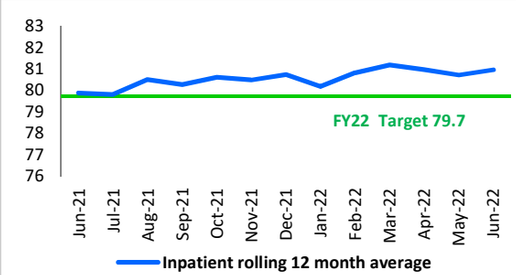
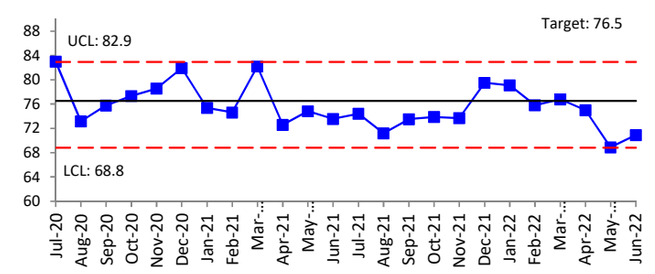
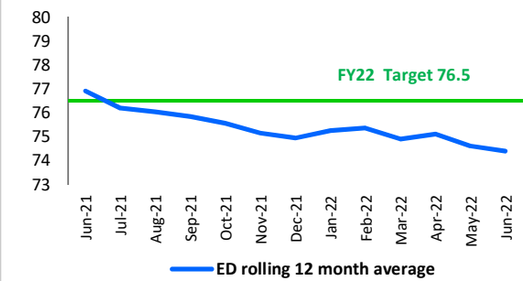
El Camino Health

# Enterprise Quality, Safety, and Experience Dashboard

**June 2022 (unless otherwise specified)**

**Month to Board Quality Committee:**

**August, 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**<br>**Mortality Index**<br>***Observed/Expected***<br>***Premier Standard Risk Calculation Mode***<br>*Latest data month: Jun, '22* | 0.64<br>(1.37%/2.13%) | 0.86<br>(1.78%/2.06%) | 0.86 | 0.90 |  |  |
| 5 | ***Organizational Goal**<br>**IP Units - HCAHPS Likelihood to Recommend -** *exec MBU,* **Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted**<br>*Latest data month: Jun, '22* | 80.3 | 80.8 | 79.6<br>(n=1983) | 79.7 |  |  |
| 6 | **ED Likelihood to Recommend**<br>**Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted**<br>*Latest data month: Jun, '22* | 70.9 | 74.5 | 76.1<br>(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.<br><br>*For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*<br>*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.<br>Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey<br>Data run criteria, 'Top Box, Received Date, and Adjusted'<br><br>**New FY22 Target received 10/18/21. Criteria changed to Adjusted score for Board reports/ external reports**<br><br>*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<br>Likelihood to Recommend - PressGaney data (not part of HCAHPS)<br>Data run criteria, 'Top Box, Received Date, and Adjusted'<br><br>**New FY22 Target received 10/18/21. Criteria changed to Adjusted score for Board reports/ external reports**<br><br>*For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* | **Press Ganey** |

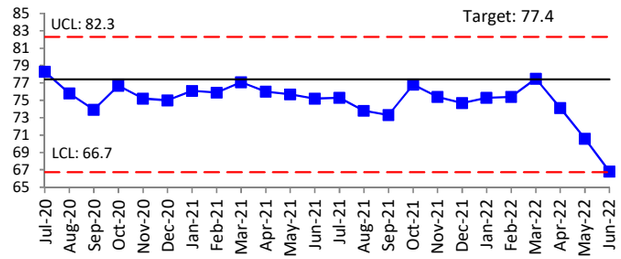
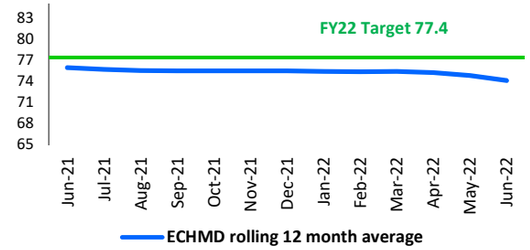
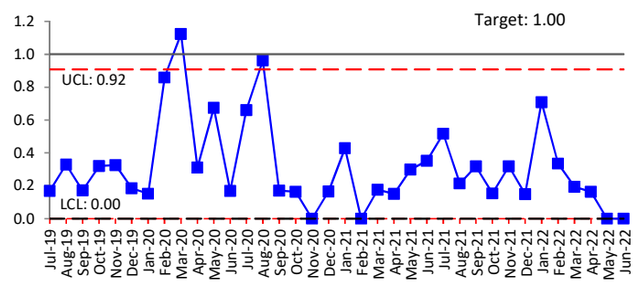
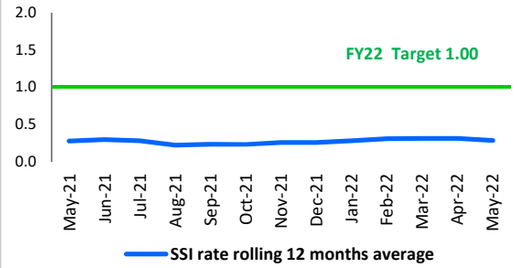
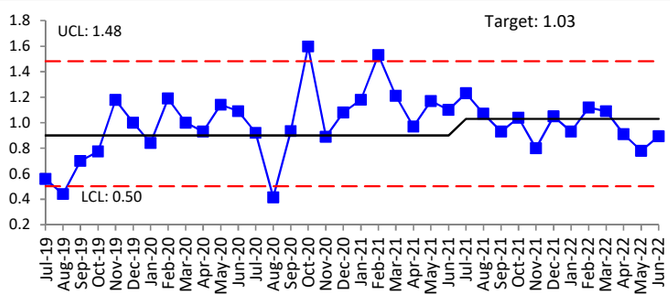
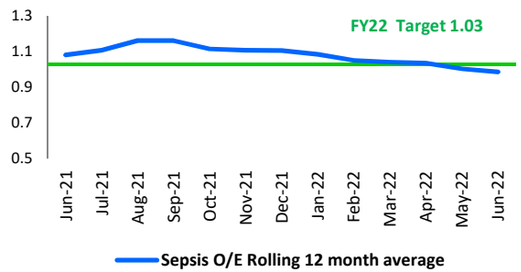
El Camino Health

# Enterprise Quality, Safety, and Experience Dashboard

**June 2022 (unless otherwise specified)**

**Month to Board Quality Committee:**

**August, 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**<br>**ECH MD : Likelihood to Recommend Care Provider**<br>(SVMD only) **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Adjusted**<br>*Latest data month: Jun, '22* | 66.8 | 74.5 | 76.0<br>(n=15,330) | 77.4 |  |  |
| 8 | **Surgical Site Infections (SSI)-Enterprise**<br>**SSI Rate = Number of SSI / Total surgical procedures x 100**<br>*Latest data month: Jun, '22* | 0.00 (0/561) | 0.27<br>(18/6738) | 0.30<br>(21/7016) | SIR<br>Goal: <=1.0<br>CDC NHSN Risk Adjusted Ratio (not an infection rate) |  |  |
| 9 | **Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)*<br>*Latest data month: June, '22* | 0.89<br>(13.18%/14.76%) | 0.98<br>(12.50%/12.82%) | 1.08<br>(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'<br><br>**New FY22 Target received 0/18/21. Criteria changed to Adjusted score for Board reports/ external reports**<br><br>*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<br>2) All surgical cases that are categorized as "clean wound class" and "clean-contaminated wound class" are considered for investigation<br>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.<br>**FY22 Target, Ent = same as last year =< 1.0 (SIR)**<br>*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**<br>*(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).<br>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.<br>*For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*<br>*LCL is set to '0' if value is less than or equal to zero.* | **Premier Quality Advisor** |

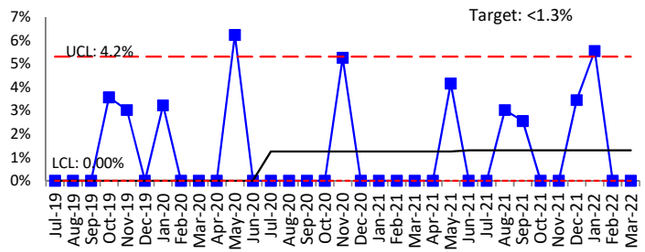
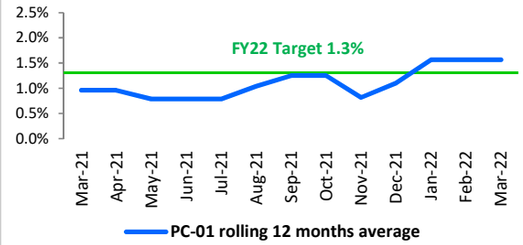
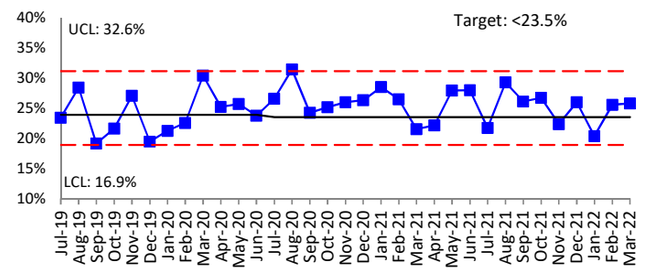
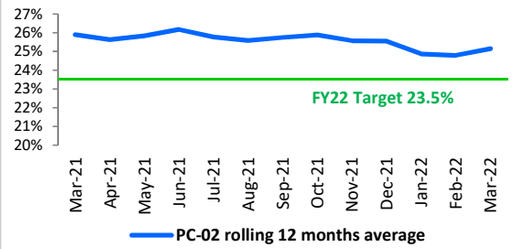
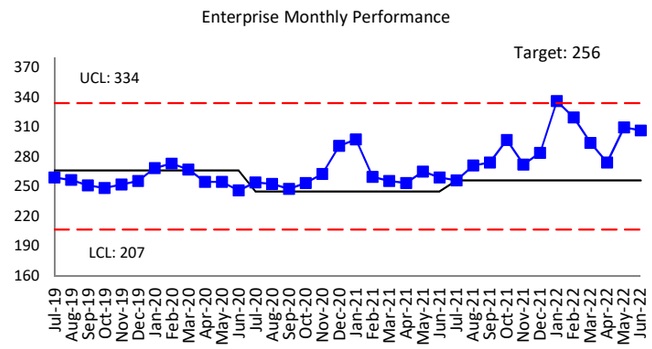
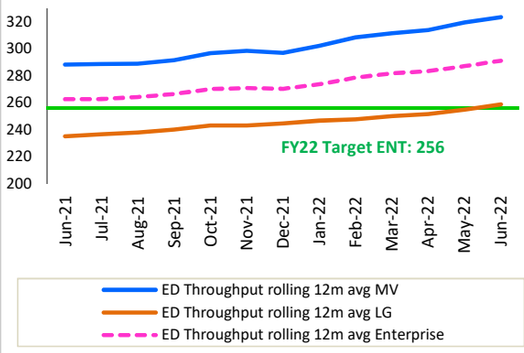
El Camino Health

# Enterprise Quality, Safety, and Experience Dashboard

**June 2022 (unless otherwise specified)**

**Month to Board Quality Committee:**

**August, 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)<br>*+Latest data month: Mar, '22* | MV: 0.0% (0/16)<br>LG: 0.0% (0/9)<br>ENT: 0.0% (0/25) | MV: 0.5% (1/199)<br>LG: 4.8% (3/63)<br>ENT: 1.5% (4/262) | MV: 0.41% (1/244)<br>LG: 1.32% (1/76)<br>ENT: 0.63% (2/320) | 1.3% |  |  |
| 11 | **PC-02: Cesarean Birth** (lower is better)<br>*+Latest data month: Mar, '22* | MV: 28.6% (46/161)<br>LG: 14.6% (6/41)<br>ENT: 25.7% (52/202) | MV: 26.3% (368/1401)<br>LG: 19.5% (65/333)<br>ENT: 25.0% (433/1734) | MV: 27.58% (422/1530)<br>LG: 20.69% (72/348)<br>ENT: 26.30% (494/1878) | 23.5% |  |  |
| 12 | ***Strategic Goal**<br>**Patient Throughput-Median Time from Arrival to ED Departure**<br>*(excludes psych patients, patients expired in the ED, newborns, & transfer between sites )*<br>*Latest data month: June, '22* | MV: 342 min<br>LG: 271 min<br>Ent: 307 min | MV: 320 min<br>LG: 259 min<br>Ent: 290 min | MV: 288 min<br>LG: 239 min<br>Ent: 264 min | MV: 263 min<br>LG: 227 min<br>Ent: 256 min |  |  |

*** SSE and MPSE available through March, '22

** Readmission data available through May, '22

+ PC-01 and PC-02 data available through March, '22



*Updated: 7/18/2022, Annotation completed 7/19/22*

# 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<br>Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed<br><br>FY22 Target, Ent. = 1.3% (same as FY21)<br><br>*For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*<br>*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<br>Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation<br><br>FY22 Target, Ent. = 23.5% (same as FY21)<br>*For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*<br><br>*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.<br>It excludes psychiatric patients, patients who expired in the ED, newborns and transfer between sites<br>FY22 Target, Ent. = 256 mins (same as FY21)<br>Arrival: Patient Arrived in ED<br>ED Departure: Departed ED<br><br>*For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* | **iCare Report: ED Admit Measurement Summary** |

*As of: 06/07/22*

# Quality Committee Follow-Up Items

| Date Requested | Committee Member Name | Item Requested | Completion Date |
|---|---|---|---|
| 2/7/2022 | Krutica Sharma | Please add the definitions back onto the Enterprise Dashboard | 3/7/2022 |
| 2/7/2022 | Krutica Sharma | Please include the Red Flags for the Medical Staff Credentialing Privileges Report | 3/7/2022 |
| 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 |
| 6/6/2022 | Holly Beeman | FY 22 Enterprise Quality Dashboard, Dr. Somersille referenced page 14, likelihood to recommend care provider, and asked what is the average of this metric. Dr. Beeman shared that she can look into this and report back at the next meeting. | |

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:** July 22, 2022
**Subject:** Patient Experience Feedback via Discharge Phone Call

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

**Summary:**

1. Situation: These comments came from patients via discharge phone calls recently discharged from the hospital which indicate the discharge process needs improvement.

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

3. Background: These comments were collected when specifically asking the patients about their discharge experience. While the comments had some positive nature—both indicated improvements needed in the discharge process.

4. Assessment: While we have a policy related to the discharge process, there continue to be elements that are either not followed comprehensively by staff or not communicated to patients and families in a way they understood. We have discussed this before and made some initial changes, however, more improvement needs to be done on the discharge process.

5. Other Reviews: None

6. Outcomes: A team has been formed as a sub group of the Readmission Steering Committee that will be solely focused on the discharge process. Observations and data collection are underway at this time to evaluate our current process, policy, and patient care staff activities. Following observations and data collection, the team will determine the actions to be taken to gain improvements in this area. The team will use LEAN principles to gain front line staff involvement in developing the improvement methodology.

**List of Attachments:**

1. See patient comments.

**Suggested Committee Discussion Questions:**

1. What types of observations and data collection will be done?

2. What LEAN tools will you be using to develop improvement initiatives?

Patient Comments Following Discharge via Discharge Phone Call

1. D/C 06/13/2022

The nurses in ICU were really gracious and very good with my husband and I! The nurses in the stroke unit we're also very good. However, the discharge process was a little disorganized. I think that the rehabilitation information should be given as we discharged. I just wish that there were options to have medical equipment that's a necessity given at a timely matter!

2. D/C 06/03/2022

Most of the steps in the discharge process were taken care of efficiently. As a patient that I feel there are two areas need to be improved: A more organized discharge process and more conversation in regards to medication

El Camino Health

**EL CAMINO HOSPITAL BOARD OF DIRECTORS**
**COMMITTEE MEETING MEMO**

**To:** Quality, Patient Care and Patient Experience Committee of the El Camino Hospital Board of Directors
**From:** Holly Beeman, MD. MBA. Chief Quality Officer
**Date:** August 1, 2022
**Subject:** Quarterly Board Quality Dashboard (STEEEP Dashboard) Q4 FY22

**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 ECH Board of Directors with a standardized high-level view 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 June FY22 unless otherwise noted. 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)**. The target for CAUTI for FY22 is a Standardized Infection Rate (SIR) of <= 0.75. Please see “Overview of the Standardized Infection Ratio” attachment. The data included in the calculation of the SIR is submitted to the National Healthcare Safety Network (NHSN) every month. ECH will learn in October 2022 what our final SIR rate is for CAUTIs. As an in process measure, we track the rate of CAUTI per catheter days. Although our target is set at a SIR, we track our rate, which for FY22 is 0.87 urinary tract infections per catheter days. We anticipate this rate will result in our achievement of a SIR <= 0.75.
        ii. **Central Line Associated Blood Stream Infection (CLABSI)**. Like the target for CAUTI, the CLABSI target is to achieve a SIR. The SIR target for CLABSI is <= 0.50. We are on track to achieve the target. This is a tremendous accomplishment given the # of central line days increased by 10.7% from Fy22 to FY21 (11,352 vs 12,567 days). There were 6 CLABSI infections in FY21 compared to only 4 CLABSI infections in FY22.

iii. **Modified Patient Safety Indicator (PSI)-90 (composite)**. The PSI 90 is a composite measure of 10 potential complications and adverse events. The FY22 target for this metric is 0.90. Our FY22 performance is unfavorably to target at 0.933. There were 4 hospital conditions in Q4 compared to 7 in Q3 (improvement). For all of FY22 there were a total of 17 hospital acquired events for this composite measure.

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

b. Timely

i. **Patient throughput – Median time arrival to ED departure**. The median time from arrival to ED departure remains longer than desired throughout FY2022. The enterprise target for FY22 is 256 minutes. Performance in June (307 minutes) and for FY22 (290 minutes) is adversely exceeds target. The Patient Throughput Value Stream for FY22 continues to focus on stabilizing the Capacity Management Center (CMC) and improving the discharge process. The discharge lounge is now staffed on weekdays from 8:30am – 5pm with a RN. We predict that will increase the in-patient units to discharge more patients by noon. Team Health continues to participate in afternoon multidisciplinary discharge rounds to help prepare for next day discharges. PAMF has agreed to add discharge planning to progress notes as a standard to improve communication and transparency across disciplines. Our executive team continues to Gemba and support the units by removing barriers to discharge by noon. Our nursing leaders continue to assist in our focus improving both discharge by noon and the electronic SBAR process. The turnaround times for radiology have been longer than desired and are impacting the efficiency and timeliness of care in the ED. This will also be an area of focus for FY23 (radiology turnaround times).

ii. **Stroke Measures**.

1. **Door to Needle**. In the fourth quarter of FY22, six patients met inclusion criteria to be included in the stroke ‘door to needle’ metric. The median time from door to intravenous thrombolytic administration was 35 minutes. 5 of the 6 times were under 45 minutes (31, 34, 35, 36, and 41.) Only one case took longer than 45 minutes.
    - Documentation plays a key role in this metric – If acceptable reasons for delay are **documented**, the case is excluded from the measure.
    - Documentation for delays were provided 4 times during Q4 (so those cases were excluded from the metric.) Reasons can include hypertension-requiring

treatment with IV medications, initial refusal and prolonged discussion with family, or determination of correct last known well time & home medications such as anticoagulants.

- Location – Three of the six cases were Los Gatos patients. One arrived by EMS & the other two arrived by car. Los Gatos sees far fewer stroke patients & gives less TNK than MV, so we continue to work to improve the process there.
- Individual physician - 3 of the 6 cases were seen by a particular teleneurologist. Teleneurology Timeliness Reports by physician are shared with Med Staff office quarterly.

2. **Door to Groin**. Fifteen patients met inclusion criteria for the Door to Groin measure in FY22. The median time from door to groin puncture was 110 minutes in FY22. Five patients (33%) had groin puncture within goal of <= 90 minutes. The median time for each quarter is; Q1 = 71 minutes, Q2 = 92.5 minutes, Q3 = 92 minutes, Q4 = 122 minutes.

c. Effective
   i. **Risk adjusted readmissions index.** The FY22 target for readmissions was to achieve an index of 0.92. This was not achieved. The FY22 index is 1.05. Please see "ECH Readmission Index Improvement August 2022" attachment.
   ii. **PC-02 NTSV C-section.** No new data to review this quarter. The data through FY22 Q3 only. Will report on PC-02 FY22Q4 and full year performance with next STEEEP quarterly dashboard.

d. Patient Centered
   i. Inpatient and outpatient surgery service areas achieved their patient experience targets in FY22. The ED performance of 74% top box likelihood to recommend is below the FY22 target of 76.5. Patients surveyed in this measure are only patients discharged from the ED (not admitted). The prolonged throughput and all this reflects is adversely affecting the patients' experience in the ED. Even with a performance of 76.5%, the ECH EDs patient experience scores compare favorably to other EDs in California and the Bay Area.
   ii. Maternal Child Health experienced significant increase in volumes of births and patients in FY22. This combined with the disruption of the renovation/construction affected our patient's experience on mother baby unit. The patient experience team deployed post discharge phone calls in FY22. The feedback from patients has been favorable. This patient outreach will continue into FY23.

**List of Attachments:**

(1) Quarterly Board Quality (STEEEP) Dashboard FY22 Q4
(2) Overview of the Standardized Infection Ratio
(3) ECH Readmission Index Improvement August 2022

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*Month to Quality Committee of the Board: August 2022*

## Quarterly Board Quality Dashboard (STEEEP) FY22, Q4 (end of June, unless otherwise specified)

| Quality Domain | Metric | Baseline | Target | Performance | | | | |
|---|---|---|---|---|---|---|---|---|
| | | FY 21 | FY 22 | FY22, Q1 | FY22, Q2 | FY22, Q3 | FY22, Q4 | FYTD22 Total |
| Safe Care | SSE (Serious Safety Events) Rate (Rolling 12 month) | 3.13 | 2.97 | 2.45 | 2.59 | 3.04 | NA | **2.70** |
| | Surgical Site Infections (SSI) | 0.30 | 1.0 (SIR) | 0.36 | 0.21 | 0.42 | 0.70 | **0.27** |
| | Catheter Associated Urinary Tract Infection (CAUTI) - HAI | 0.37 | <= 0.75 | 1.32 | 0.81 | 0.23 | 1.17 | **0.87** |
| | Central Line Associated Blood Stream Infection (CLABSI) - HAI | 0.53 | <= 0.50 | 0.33 | 0.00 | 0.88 | 0.00 | **0.32** |
| | Modified PSI-90 CMS HAC Reduction Program (composite) | 0.919 | 0.90 | 0.884 | 0.872 | 1.073 | 1.144 | **0.933** |
| Timely | HVI STEMI % 1st Medical Contact to Device Time w/I 90 minutes | 100% | 100% | 100% (13/13) | 100% (15/15) | 100% (15/15) | NA | **100%** |
| | Patient Throughput - Median Time Arrival to ED Departure | 264 min | 256 min | 267 min | 284 min | 317 min | 297 min | **290 min** |
| | Stroke: TTITT (time to intravenous thrombolytic therapy) <= 30 min | 57.5% (14/23) | 50% | 25% (1/4) | 10% (1/10) | 75.0% (6/8) | 0% (0/6) | **28.6%** |
| | Stroke: Door-to-Groin <= 75 minutes | 16.7% (3/18) | 50% | 50% (1/2) | 14.3% (1/7) | 0% (0/2) | 0% (0/4) | **13.3%** |
| | Stroke: Door-to-Groin <= 90 minutes | 50% (9/18) | NA | 50% (1/2) | 28.6% (2/7) | 50% (1/2) | 25% (1/4) | **33.3%** |
| Effective | Risk Adjusted Readmissions Index | 0.93 | 0.92 | 1.05 | 0.96 | 1.12 | 1.06 | **1.05** |
| | Risk Adjusted Mortality Index | 0.86 | 0.90 | 0.99 | 0.87 | 0.86 | 0.71 | **0.85** |
| | Sepsis Mortality Index | 1.08 | 1.03 | 1.06 | 0.97 | 1.03 | 0.86 | **0.98** |
| | PC-01 Elective Delivery Prior to 39 Weeks Gestation | ENT: 0.63% | 1.3% | 1.8% | 1.1% | 1.6% | NA | **1.5%** |
| | PC-02 NTSV C-Section | ENT: 26.3% | 23.5% | 25.8% | 25.0% | 24.1% | NA | **25.0%** |
| | ECHMN: CMS 165 Controlling High Blood Pressure | 59.0% | >= 59% | 60.0% | 59.0% | 60.0% | 60.0% | **64.0%** |
| | ECHMN: CMS 122 Diabetes Hemoglobin A1c Poor Control | 30.0% | <= 30 | 24.0% | 26.0% | 32.0% | 31.0% | **29.0%** |
| Efficient | Arithmetic Observed LOS/ Geometric Expected LOS | 1.29 | 1.30 | 1.35 | 1.33 | 1.40 | 1.33 | **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 only) | | **0.99** |
| Equitable | Hospital Charity Care Support | $19.7 mil | NA | $7.2 mil | $11.6 mil | $7.6 mil | $10.1 mil | **$36.5 mil** |
| | Clinic Charity Care Support | $14.9k | NA | $7.5k | $3.1k | $5.3k | $6.8k | **$22.7k** |
| | Language Line Unmet Requests | 0.72% | <1% | 0.62% | 0.36% | 0.15% | 0.37% | **0.37%** |
| | Length of Stay Disparity (Top 3 races) 40% patients did not report their race | Black: 4.0 | NA | 3.77 | 4.03 | 4.01 | 5.27 | **4.36** |
| | | White: 3.89 | | 4.3 | 3.88 | 4.20 | 3.96 | **3.96** |
| | | Asian: 3.57 | | 3.59 | 3.67 | 3.67 | 3.49 | **3.61** |
| Patient-centered | IP Units Enterprise - HCAHPS Likelihood to Recommend | 79.6 | 79.7 | 82 | 80.23 | 82.1 | 80.8 | **80.8** |
| | ED - Likelihood to Recommend (PG) | 76.1 | 76.5 | 73.1 | 75.7 | 77.23 | 74.5 | **74.5** |
| | ECHMN - Likelihood to Recommend Care Provider (NPS) | 76.0 | 77.4 | 74.1 | 75.6 | 76.1 | 70.5 | **74.5** |
| | MCH - HCAHPS Likelihood to Recommend | 81.8 | 82.0 | 79.4 | 80.5 | 82.1 | 83.1 | **81.3** |
| | OAS - HCAHPS Likelihood to Recommend | 85.7 | 86.1 | 85.5 | 87.6 | 86.77 | 85.8 | **86.4** |

*Updated: 7/20/2022*

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

**Cell:** H6

**Comment:** Indu_a:

Q4 data NA, delay by 3 months.  SSE Serious Safety Event Rates Note 7/20/22:  MMcIntyre: Most recent month of SSE classification that's been completed is March, 2022.

**Cell:** H11

**Comment:** Indu_a:

Q4 data NA, delay by 3 months  HVI STEMI 7/20/22 M. McIntyre:  Q4 to be completed by 8/31/22 (per: Shuwen Chen, Sr. Clinical Data Specialist)

**Cell:** H16

**Comment:** Indu_a:

Q4 data includes April and May only RISK ADJUSTED READMISSION  7/20/22 M.McIntyre RN:  The full 4th quarter readmission metric will not be available until late September 2022.

**Cell:** H19

**Comment:** Indu_a:

Q4 data not available until Sept 22, delay by 3 months. PC-01 7/20/22  M. McIntyre, RN:  FY22Q3 data will not truly be finalized until data has been submitted to CMS on 8/1/22; FY22Q4 will not be finalized until data has been submitted to CMS on 11/1/22.

**Cell:** H20

**Comment:** Indu_a:

Q4 data not available until Sept 22, delay by 3 months  PC-02 7/20/22 M. McIntyre, RN:  FY22Q3 data will not truly be finalized until data has been submitted to CMS on 8/1/22; FY22Q4 will not be finalized until data has been submitted to CMS on 11/1/22.

# THE NHSN STANDARDIZED INFECTION RATIO (SIR)

## *A Guide to the SIR*

*Updated April 2022. Please see Pages 14- 48.*

The Standardized Infection Ratio (SIR) is the primary summary measure used by the National Healthcare Safety Network (NHSN) to track healthcare-associated infections (HAIs). As NHSN grows, both in its user-base and surveillance capability, the SIR continues to evolve. Highlighting the SIR and changes resulting from an updated baseline, this document is intended to serve both as guidance for those who are new to this metric as well as a useful reference for more experienced infection prevention professionals.



National Center for Emerging and Zoonotic Infectious Diseases
Division of Healthcare Quality Promotion

# Overview of the Standardized Infection Ratio (SIR)

## What is the SIR?

The standardized infection ratio (SIR) is a summary measure used to track HAIs at a national, state, or local level over time. The SIR adjusts for various facility and/or patient-level factors that contribute to HAI risk within each facility. The method of calculating an SIR is similar to the method used to calculate the Standardized Mortality Ratio (SMR), a summary statistic widely used in public health to analyze mortality data. In HAI data analysis, the SIR compares the actual number of HAIs reported to the number that would be predicted, given the standard population (i.e., NHSN baseline), adjusting for several risk factors that have been found to be significantly associated with differences in infection incidence. In other words, an SIR greater than 1.0 indicates that more HAIs were observed than predicted; conversely, an SIR less than 1.0 indicates that fewer HAIs were observed than predicted. SIRs are currently calculated in NHSN for the following HAI types: central line-associated bloodstream infections (CLABSI), mucosal barrier injury laboratory-confirmed bloodstream infections (MBI-LCBI), catheter-associated urinary tract infections (CAUTI), surgical site infections (SSI), *Clostridioides difficile* infections (CDI), methicillin-resistant *Staphylococcus aureus* bloodstream infections (MRSA), and ventilator-associated events (VAE).

## Why not rates?

In the past, NHSN has published annual HAI rates for device-associated infections. These rates, or pooled means, were calculated using aggregate data reported to NHSN. The total number of infections was divided by the applicable number of device days for that time period. However, a problem with strictly using pooled mean rates is that they cannot reflect differences in risk between populations, and therefore lose comparability over time and across entities. For example, calculating rates from two facilities serving entirely different patient populations can lead to an unfair comparison. One solution to this problem is the stratification of pooled means, as was done with location-stratified CLABSI and CAUTI pooled means. However, this method only allows for comparison of rates within strata and does not lend itself to calculating an overall performance metric for a facility.

Instead, the SIR allows users to summarize data by more than a single stratum (e.g., location or procedure category), adjusting for differences in the incidence of infection among the strata. For example, NHSN allows users to obtain one CLABSI SIR for their facility, adjusting for all locations reported. Similarly, users can also obtain one CLABSI SIR for all intensive care units in their facility.

Additionally, the SIR allows for a comparison to the national benchmark from a baseline time period, and can be used to measure progress from a single point in time. In other words, the SIR permits comparisons between the number of infections experienced by a facility, group, or state to the number of infections that were predicted to have occurred based on national data (i.e., baseline data).

# ECH Readmissions Index Performance Improvement

*Holly Beeman, MD, MBA,Chief Quality Officer*

*August 1, 2022,*

*Quality, Patient Care and Patient Experience Committee of the El Camino Hospital Board of Directors*

# Situation

Fiscal Year 2022

More patients are being readmitted than
prior years
expected (based on risk adjustment)

# FY22 Readmission Index Target = 0.92

Month of May 2022 = 1.10

FY22 Readmission Index YTD = 1.05

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# Readmission Index--Measure Definition

The outcome for this measure is unplanned all-cause 30-day readmission after an admission for any condition.

A readmission is a subsequent inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission.

Any readmission is eligible to be counted as an outcome except those that are considered planned.

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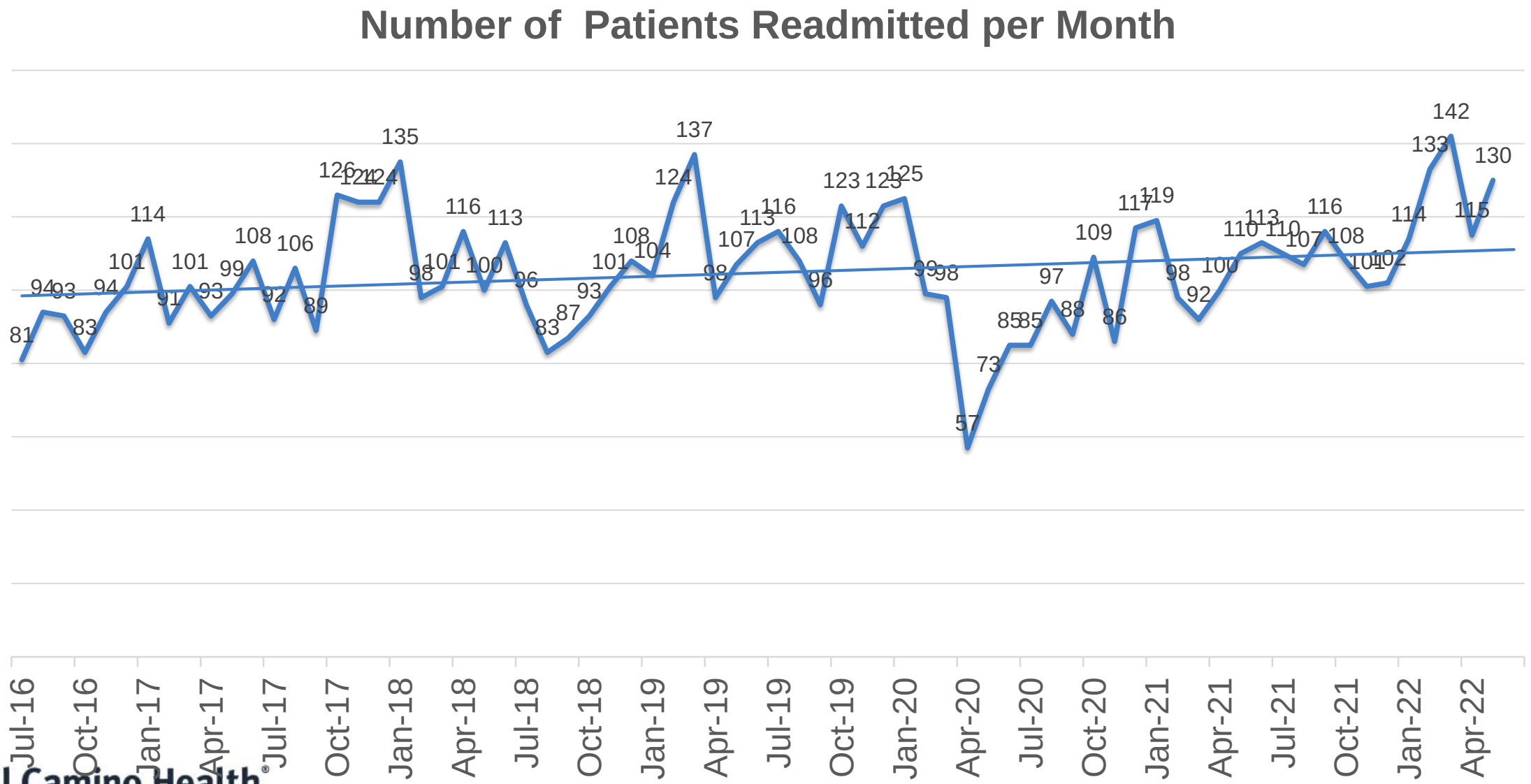
# El Camino Health performance

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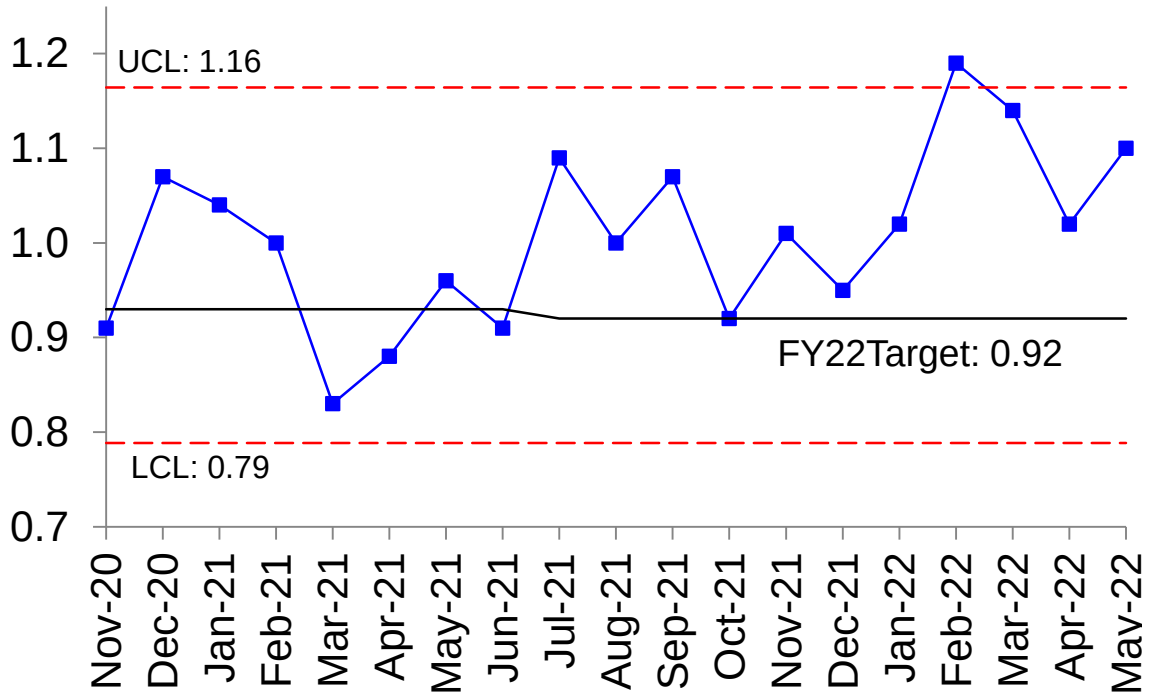
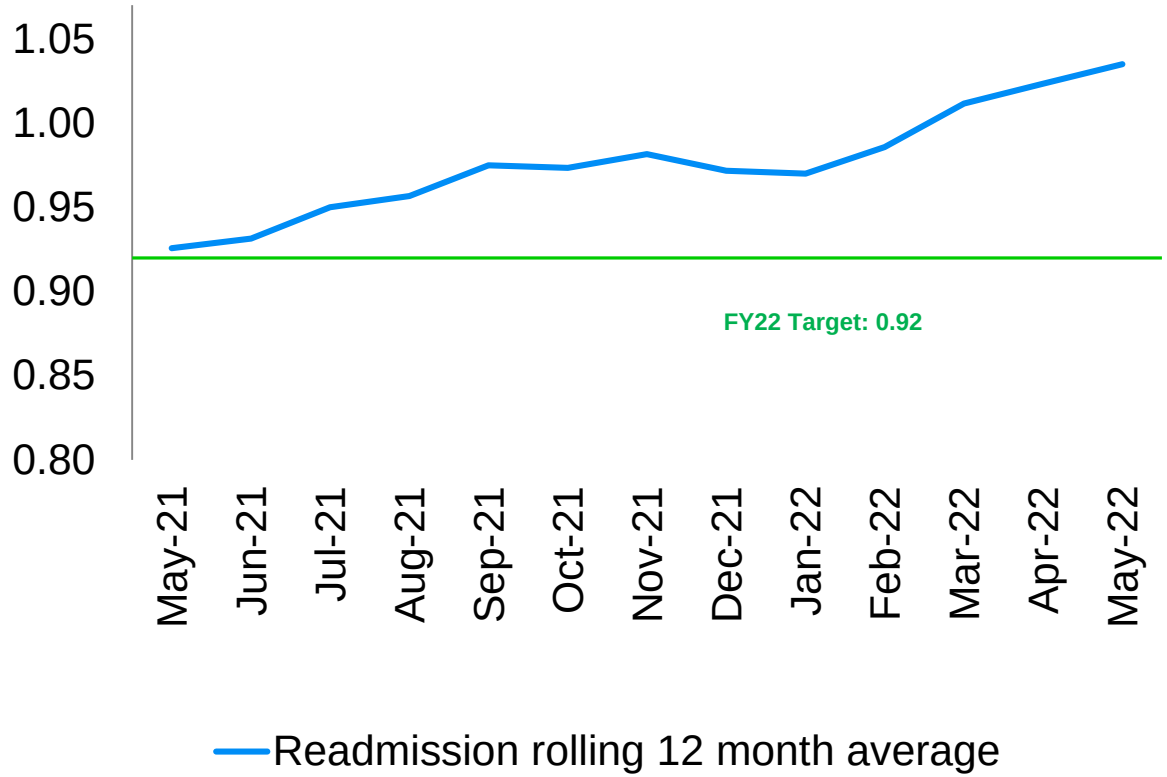
# Readmission Observed/Expected Index Trends

## Trend




## Rolling 12 Month Average

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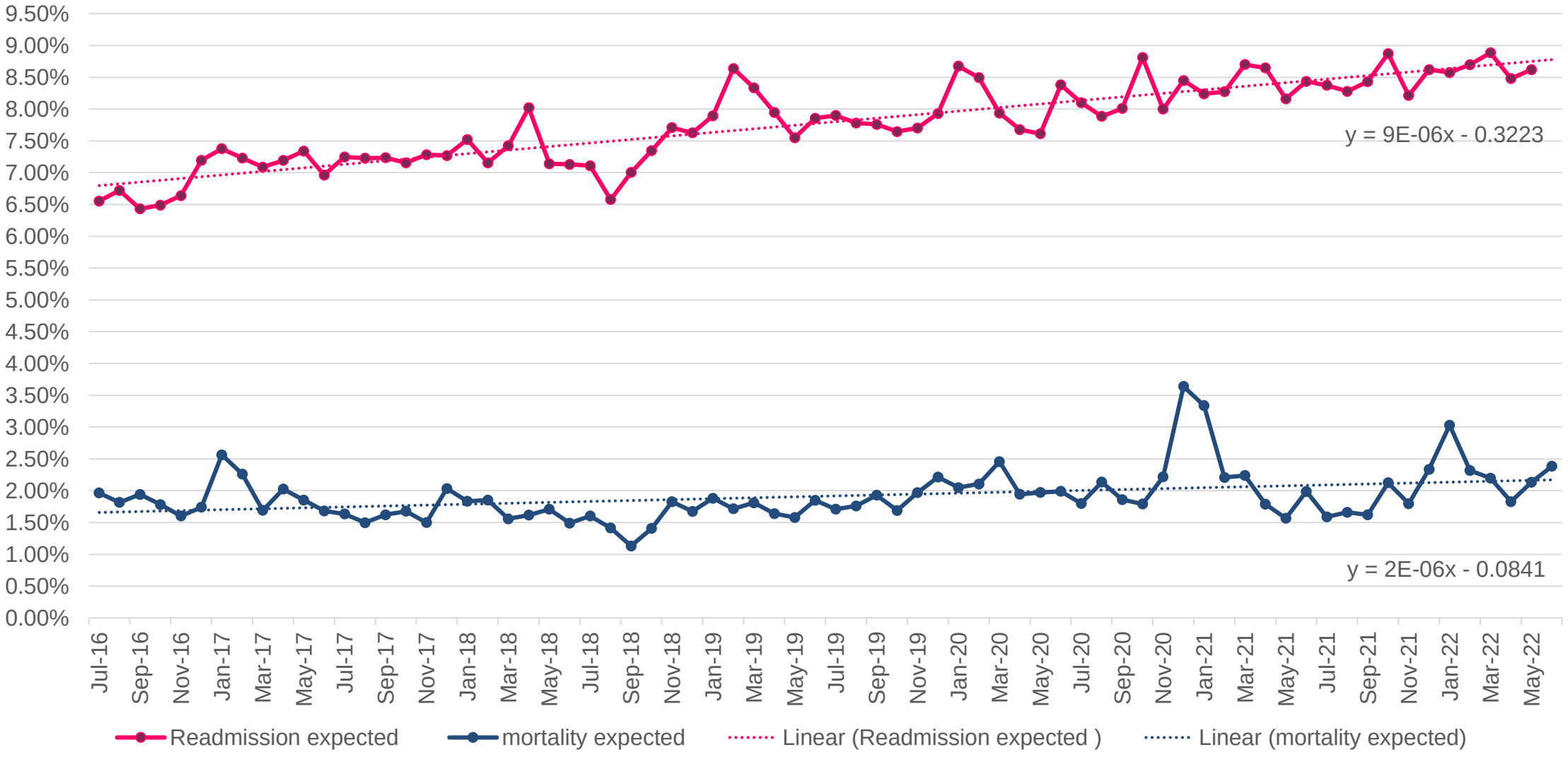
# Mortality and Readmissions "Expected Rate" Trends ECH 2016-2022

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# Healthcare Ecosystem

Long term care

Primary Care Office

Food

Mental Health resources

Acute Rehab

Skilled Nursing

Home

Transportation

Medical Clinic

Hospital

Social support/Family

Cost of and access to medications

Community support

Hospice

Health Insurance

Employment

Social support

Home Health

# Why this matters?

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# Important

~20% preventable

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# Performance Improvement Efforts

Index Admission

Post Acute

E.D.


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# Index Admission

- Inpatient stay
  - Disease/condition education
  - Medication reconciliation and education
  - Care-giver identification and collaboration
  - Begin discharge planning at time of admission
  - Goals of care discussion
  - Palliative care consultation (if appropriate)
- Discharge
  - Timing and location of discharge = clinically appropriate
  - **Discharge education of patient and their care-giver**
  - **Warm hand off and sharing of information with primary care team, and, accepting facility**

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- Discharge education of patient and their care-giver
    - Plan
        - » Observe and audit discharge patient teaching on units
        - » Compare to best practices (Project RED)

- Warm hand off and sharing of information with primary care team, and, accepting facility—
    - Plan
        - » Assess current state of readmission rate by SNF
        - » Evaluate current state of SNF/ECH collaboration and communication

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# Post-Acute

What are the transitional needs from inpatient to outpatient care for patients based on specific populations?

Based on detailed review, slicing and dicing of ECH readmission data, these four populations require further study to understand WHY they are being readmitted

- Patients readmitted for less than 48 hours
- Alcohol/drug dependence
- Vulnerable population (patients with => 4 hospital admissions per 12 months)
- Sepsis


# Post Acute patient outreach and support

Possible solutions to support patients after discharge

1. Complex care clinic
2. Medication compliance support
3. Patient phone calls and out reach (Conversa, Cipher)
4. Connect at Home
5. Outpatient hospice
6. Home grown virtual post acute care staffed by nurse (local vs remote)

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# What is happening in the SNFs?

1. Staffing
    1. Less experienced staff quicker to readmit
    2. Decrease in compliance with patient care standards

2. Resource constrained
    1. Sitters
    2. PPE
    3. Infection prevention experts, training, presence

(Hypotheses, not confirmed with data)

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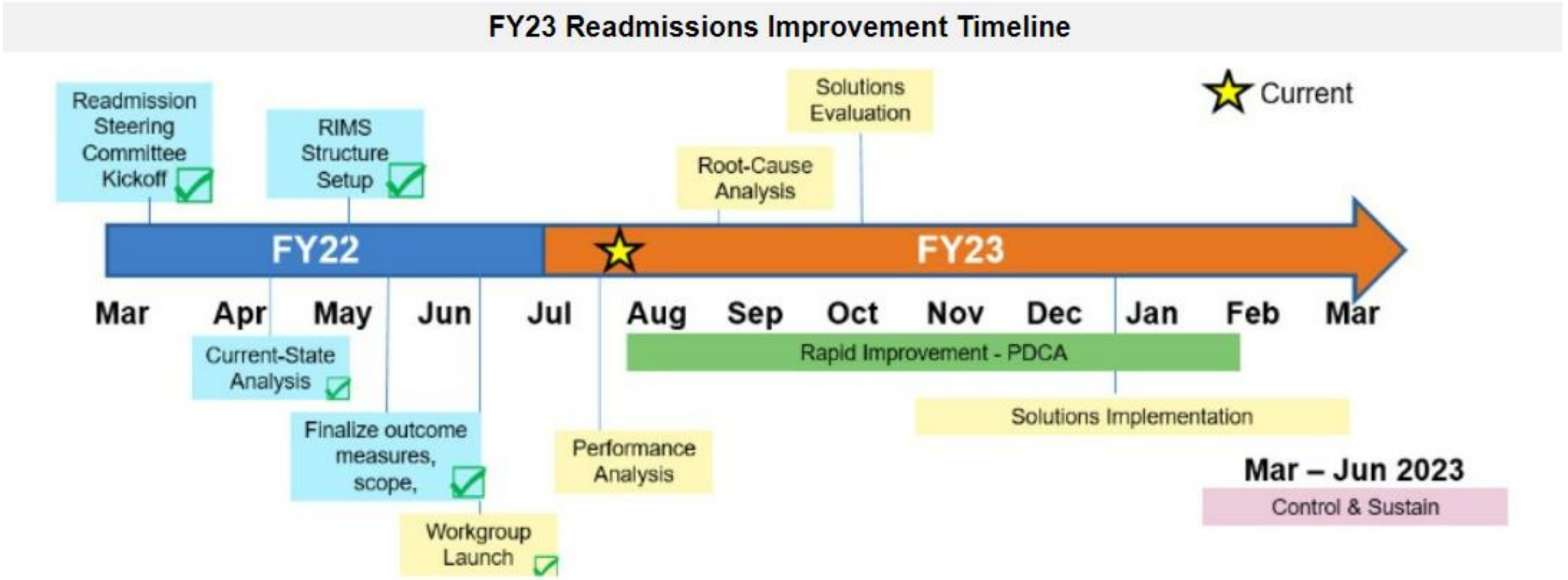
# Patients not able to be ‘home’ come to the ED

1. Goal
   Intervene BEFORE a patient (their caregivers) feel the best choice is to return to the ED

2. Decision making support in the ED
   1. Medical vs social support gaps
   2. Social work for patients with substance abuse
   3. Case management staffing
   4. Evaluation and adjustment of patients admitted to observation vs inpatient
   5. Automatic palliative care consultation ordered in ED?

# Plan Review

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# Discussion….

***"…the secret of the care of the patient is in caring for the patient."***

Francis Peabody, MD (1881-1927)

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**EL CAMINO HOSPITAL**
**COMMITTEE MEETING COVER MEMO**

**To:** Quality Committee of the Board
**From:** Shahab Dadjou, Interim President ECHMN and Ute Burness, RN, VP of Quality, ECHMN
**Date:** August 1, 2022
**Subject:** ECHMN Quarterly Quality Report

**Purpose:** Provide the Board Quality Committee with a quarterly update on the status of ECHMN quality.

**Summary:**

**1.** Situation: The system Board of Directors is very interested in understanding and tracking the quality and service performance of the various components of ECHMN. It was agreed that the Board Quality Committee would review the status of quality and service performance within ECHMN on a quarterly basis.

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

**3.** Background: ECHMN is a wholly owned subsidiary of El Camino Hospital established as a separate corporation with its own tax ID number. It was established to develop an ambulatory care capability so that the El Camino Health continuum of care could extend beyond the traditional hospital acute care and hospital based out patient care.

**4.** Assessment: There are three key areas of focus for ECHMN with respect to quality and service:

**A.** HEDIS (Healthcare Effectiveness Data and Information set)
**B.** MIPS (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 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 Q4 is a composite score of 3.6 which is a increase from the previous The target composite score for FY22 is 3.6. ECHMN has achieved the target goal to be at 3.6 for FY22

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 4th quarter was 71.177.5,, which is below our target of 77.4; ECMHN started sending surveys through Press Ganey and the 4th quarter score was 82.77. ECHMN will be transitioning all surveys through Press Ganey as of July 1, 2022. ECHMN has approved 15 initial appointments and 53 reappointments during the 4th quarter. We passed the annual delegation audits for seven (7) health plans.

**5. 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?

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Medical Network

# El Camino Health Quality Committee Meeting

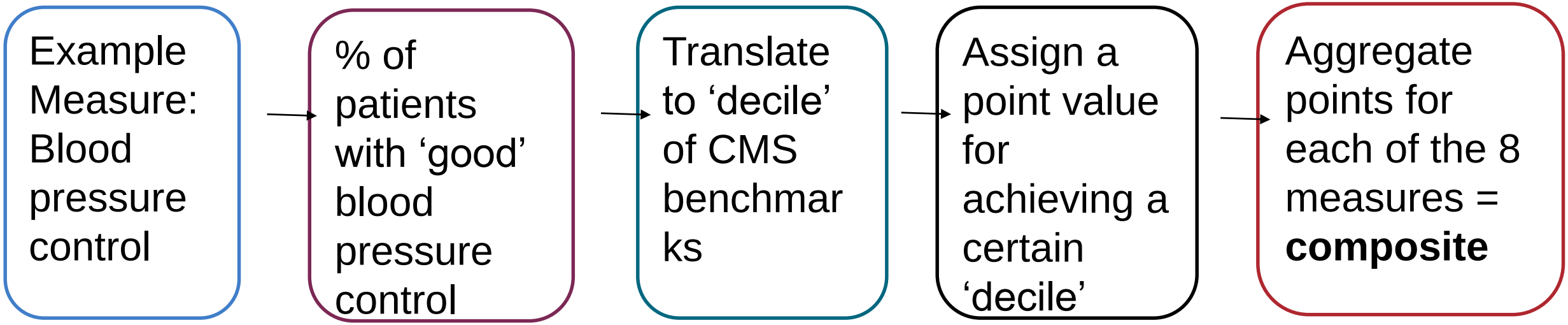
*Shahab Dadjou, Interim President*

*Ute Burness, RN, VP Quality, ECHMN*

*August 1, 2022*

# Fiscal Year 2022 Quality Measures

## Method *Review*



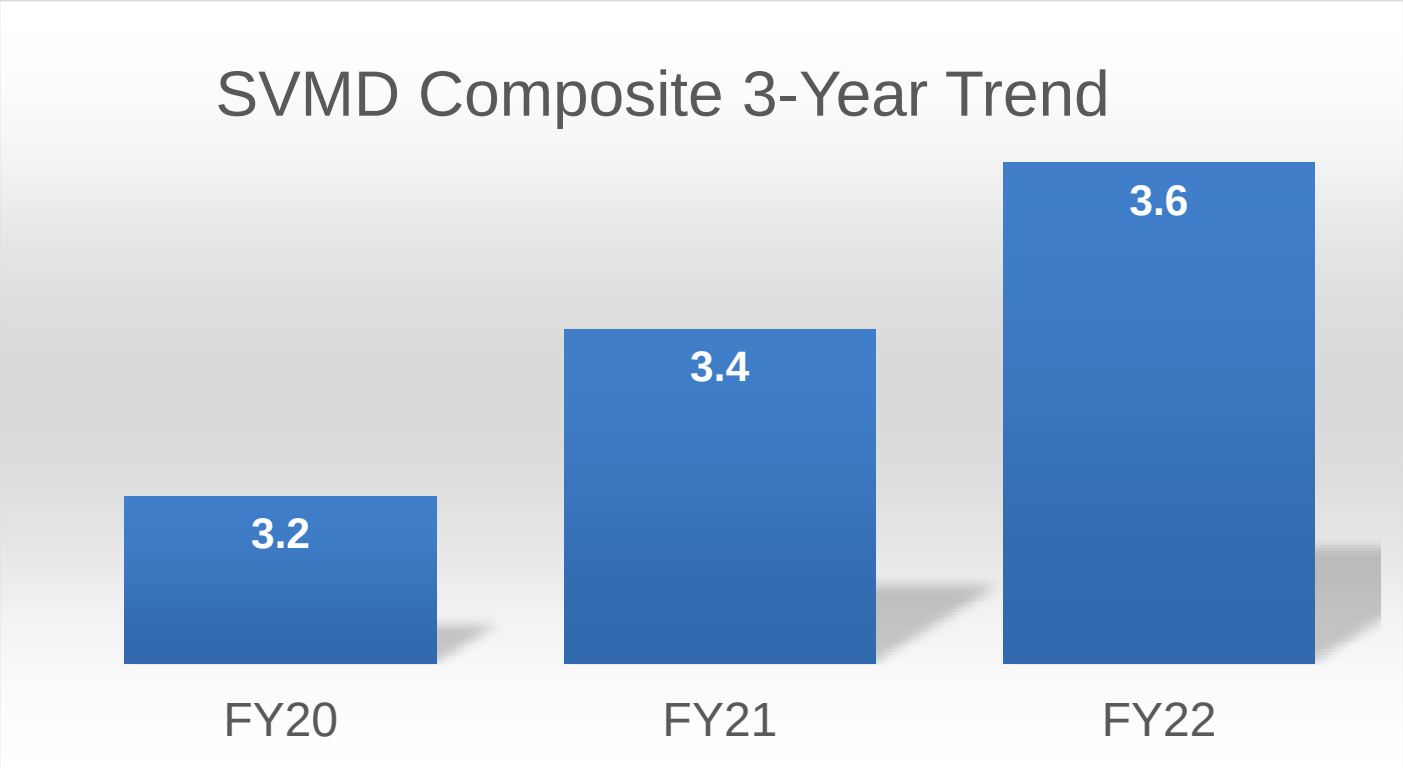
# Conversion from ‘decile’ to point value

| 2020 Benchmarks | 2 | | 3 | | 4 | | 5 | |
|---|---|---|---|---|---|---|---|---|
| Measure Title | Decile 3 | Decile 4 | Decile 5 | Decile 6 | Decile 7 | Decile 8 | Decile 9 | Decile 10 |
| Documentation of Current Medications in the Medical Record | 6.46 - 66.01 | 66.02 - 88.81 | 88.82 - 97.34 | 97.35 - 99.68 | 99.69 - 99.99 | -- | -- | 100 |
| Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan | 0.42 - 17.47 | 17.48 - 23.88 | 23.89 - 37.38 | 37.39 - 73.96 | 73.97 - 94.14 | 94.15 - 98.35 | 98.36 - 99.99 | 100 |
| Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | >= 99.46 | 99.45 - 92.62 | 92.61 - 74.48 | 74.47 - 59.09 | 59.08 - 46.85 | 46.84 - 37.89 | 37.88 - 31.41 | <= 31.40 |
| Breast Cancer Screening | 0.28 - 7.3 | 7.31 - 27.28 | 27.29 - 51.55 | 51.56 - 69.35 | 69.36 - 81.47 | 81.48 - 88.26 | 88.27 - 98.54 | >=98.55 |
| Colorectal Cancer Screening | 0.13 - 2.58 | 2.59 - 19.33 | 19.34 - 45.63 | 45.64 - 70 | 70.01 - 84.49 | 84.5 - 90.81 | 90.82 - 99.38 | >=99.39 |
| Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | 0.93 - 7.26 | 7.27 - 24.15 | 24.16 - 73.97 | 73.98 - 90.28 | 90.29 - 97.1 | 97.11 - 99.99 | -- | 100 |
| Falls: Screening for Future Fall Risk | 0.04 - 1.38 | 1.39 - 21.67 | 21.68 - 65.26 | 65.27 - 90.35 | 90.36 - 98.15 | 98.16 - 99.5 | 99.51 - 99.99 | 100 |
| Controlling High Blood Pressure | 20 - 29.99 | 30 - 39.99 | 40 - 49.99 | 50 - 59.99 | 60 - 69.99 | 70 - 79.99 | 80 - 89.99 | >= 90 |

# Fiscal Year 2022

FY22 Composite Target = 3.6

**FY22 Composite Performance = 3.6**

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# Individual Measure Performance

| Metric | FY 22 Target | FY22 Performance |
|---|---|---|
| CMS 68- Documentation of Current Meds | 91% | **93%** |
| CMS 69- Prevention and Screening Body Mass Index – Screening and Follow Up Plan | 53% | **55%** |
| CMS 122- Diabetes: Hemoglobin A1C Poor Control (lower % is better) | <29% | **29%** |
| CMS 125- Breast Cancer Screening | 55% | 62% |
| CMS 130- Colorectal Cancer Screening | 44% | **53%** |
| CMS 138- Tobacco Screening and Counseling | 94% | **97%** |
| CMS 139- Fall Risk Screening | 83% | **91%** |
| CMS 165- Controlling Blood Pressure | 57% | **62%** |

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# Changes for FY 23 Quality Reporting

- Method of using a composite of averages of all doctors, for measures that are truly measures of primary care clinicians, is not providing a comprehensive or accurate picture of the quality and patient experience in ECHMN
  - For example…. You just saw our composite and individual measure performance for FY22. However, that data included all providers, including our (urgent care and specialty providers

# FY23 Quality Reporting - cont.

- Here is the FY22 Data by PCP only:

| Metric | FY22 |
|---|---|
| **Composite Score** | **3.75** |
| CMS 68- Documentation of Current Meds | 97% |
| CMS 69- Prevention and Screening Body Mass Index – Screening and Follow Up Plan | 63% |
| CMS 122- Diabetes: Hemoglobin A1C Poor Control (lower % is better) | 23% |
| CMS 125- Breast Cancer Screening | 71% |
| CMS 130- Colorectal Cancer Screening | 58% |
| CMS 138- Tobacco Screening and Counseling | 97% |
| CMS 139- Fall Risk Screening | 97% |
| CMS 165- Controlling Blood Pressure | 60% |

# FY23 Quality Reporting – cont.

- If you look at the diabetes measures side by side, you can see that the PCP's which should be taking care of the diabetes are scoring better than when we combine all the providers.

  - PCP scored 23%
  - All Providers scored 29%

- *_For this measure a lower number is better. The measure is looking at the percentage of patients that their HBA1c is not controlled._

# FY23 ECHMN Dashboard

| FY23 ECHMN Dashboard | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Domain | Measure | Baseline FY22 | Target | Description | FY23 Q2 | FY23 Q3 | FY23 Q4 | FYTD23 Total |
| Safe | Blood Pressure management (primary care only) | 60% | 67.50% | | | | | |
| | Diabetes management-HbA1C <9% (primary care only) | 24% | <20% | | | | | |
| | Breast cancer screening (primary care only) | 69% | 73.50% | | | | | |
| | Colon cancer screening (primary care only) | 57% | 61% | | | | | |
| | Annual flu vaccination (primary care only) | 70% | 75% | | | | | |
| | Medication Reconciliation (primary care only) | 98% | 98.40% | | | | | |
| Frictionless | Access 3na for primary care | 18.12 days | 25% improvement | | | | | |
| | Access 3na for specialty care | 20.42 days | 25% improvement | | | | | |
| | Patient enrollment in my chart | 63% | 63% | | | | | |
| | Clinician response to my chart patient message < 48 hours? | 1.48 days | 1.2 days | | | | | |
| Patient Centered | Primary Care LTR | 83.2 | | | | | | |
| | Specialty Care LTR | 86.8 | | | | | | |
| | Urgent Care LTR | 78 | | | | | | |

# Overview of the FY23 ECHMN Dashboard

- “Safe” domain:
  - Annual flu vaccine was added as a quality measures and the targets have been increased. the quality measures are for primary care physicians (PCP) only.
- “Frictionless” Domain: This is a new section.
  - ***Third next available appointment (3NAA)*** measures access to care and how long patients have to wait to be seen. The measure is used to assess the average number of days to the third next available appointment.
  - ***Patient Enrollment in My Chart*** measures the percentage of patients that have signed up for our patient portal.
  - ***Response to “mychart” messages*** measures the amount of time it takes for the physician to respond to their my chart messages.

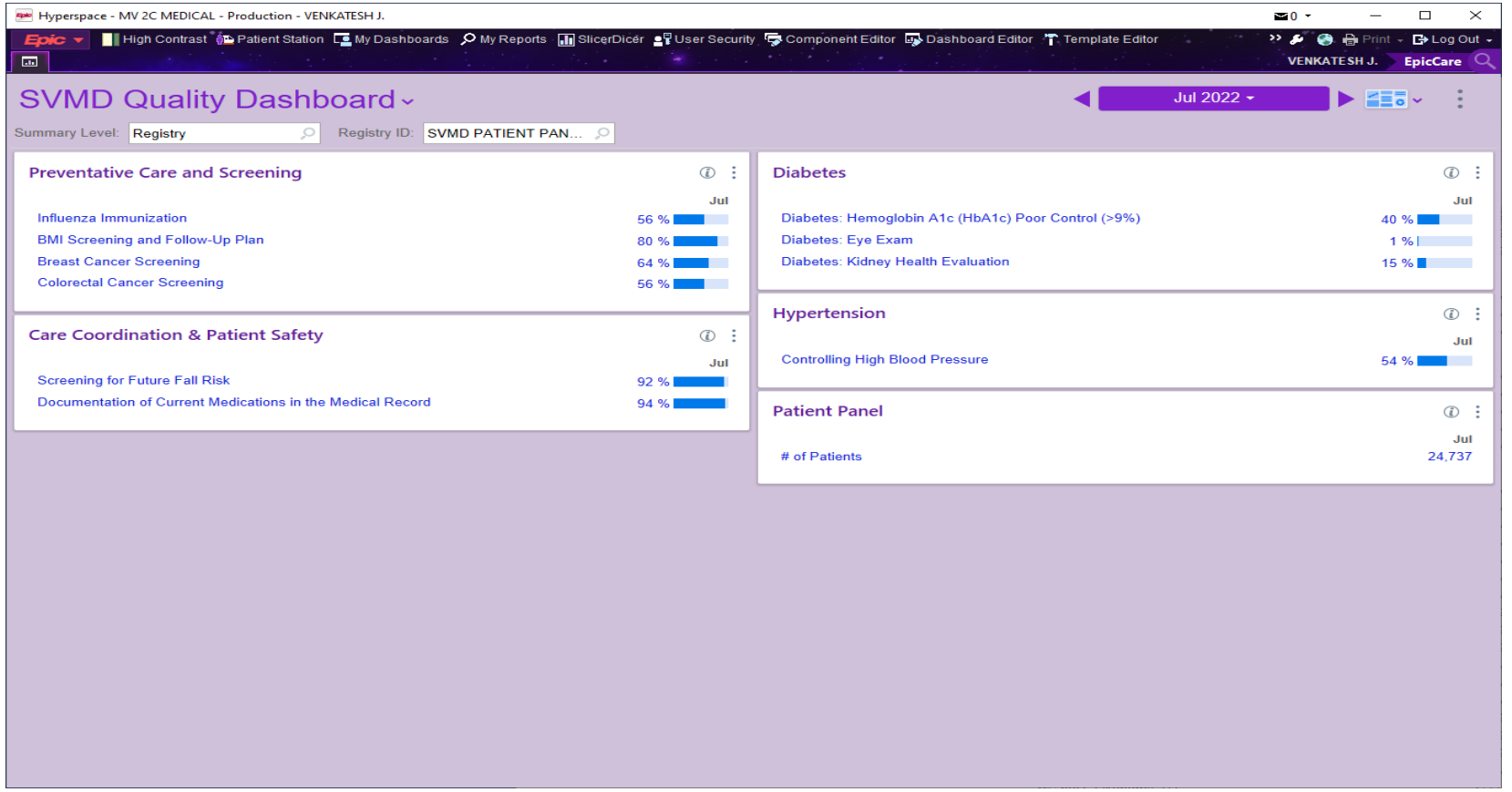
***“***Patient Centered” domain:

Nothing new. We are still measuring the Likelihood to Recommend (LTR). We have switched to using the Press Ganey survey, which allows us to get better data than when we were using NRC.

# FY23 Physician Dashboard

- The quality team has been working with the EPIC team to create a new physician dashboard.
- The new dashboard will allow the physicians to see their patient panel as well as their performance on each metric.
- The PCP will be able to drill down by each measure and see what each patient needs to have done.

# Sample of the FY 23 Physician Dashboard

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# Questions?