El Camino Health

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

Tuesday, September 5, 2023 – 5:30 pm
El Camino Health | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 941 6370 3091#. No participant code. Just press #.

PURPOSE: To advise and assist the El Camino Health (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 Quality Committee Chair		**5:30 – 5:32 pm**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Carol Somersille, MD Quality Committee Chair	*public comment*	**possible motion 5:32 – 5:33**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair		**information 5:33 – 5:34**
4.	**PUBLIC COMMUNICATION**	Carol Somersille, MD Quality Committee Chair		**information 5:34 – 5:37**
5.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Quality Committee Meeting (08/07/2023) ***Information*** b. FY24 Enterprise Quality Dashboard c. Progress against FY24 Committee Goals d. QC Follow-Up Items	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 5:37 – 5:52**
6.	**CHAIR'S REPORT**	Carol Somersille, MD Quality Committee Chair		**information 5:52 – 5:57**
7.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer		**discussion 5:57 – 6:07**
8.	**PATIENT EXPERIENCE**	Christine Cunningham, MBA Chief Experience Officer		**discussion 6:07 – 6:27**
9.	**REFRESH STEEEP MEASURES WITH COMMITTEE FOR FY24**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:27 – 6:37**
10.	**ADJOURN TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 6:37 – 6:38**

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair		**information** **6:38 – 6:39**
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 (08/07/2023) ***Information*** *Health and Safety Code Section 32155* b. Quality Council Minutes (08/02/2023)	Carol Somersille, MD Quality Committee Chair		**motion required** **6:39 – 6:44**
13.	*Health and Safety Code Section 32106(b)* - for a report and discussion involving healthcare facility trade secrets: **ANNUAL CULTURE OF SAFETY SURVEY RESULTS**	Mark Adams, MD, Chief Medical Officer		**discussion** **6:44 – 6:59**
14.	*Health and Safety Code Section 32155* **ANNUAL PATIENT SAFETY REPORT**	Mark Adams, MD, Chief Medical Officer Sheetal Shah, Sr. Director Risk Management and Patient Safety		**discussion** **6:59 – 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.	*Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management:* **EXECUTIVE SESSION**	Carol Somersille, MD Quality Committee Chair		**discussion** **7:29 – 7:39**
18.	**ADJOURN TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair		**motion required** **7:39 - 7:40**
19.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair		**information** **7:40 – 7:41**
20.	**ROUNDTABLE**	Carol Somersille, MD Quality Committee Chair		**discussion** **7:41 – 7:44**
21.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required** **7:44 – 7:45 pm**

Next Meeting: November 6, 2023, December 4, 2023, February 5, 2024, March 4, 2024, May 6, 2024, June 3, 2024

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Health Board of Directors
Monday, August 7, 2023
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent	Others Present
Carol Somersille, MD	**Prithvi Legha,** MD	**Holly Beeman,** MD, MBA, CQO
Jack Po, MD		**Dan Woods,** CEO
Krutica Sharma, MD**		**Mark Adams,** MD, CMO
Melora Simon		**Deb Muro,** CIO**
John Zoglin		**Christine Cunningham**, Chief Experience and Performance Improvement Officer
Philip Ho, MD		**Cheryl Reinking,** DPN, RN, CNO
Pancho Chang**		**Shreyas Mallur,** MD, ACMO
		Lyn Garrett, Senior Director, Quality
		Shahab Dadjou, President, El Camino Health Medical Network
		Ute Burness, VP of Quality and Payer Relations
	**via teleconference	**Tracy Fowler,** Director, Governance Services
		Nicole Hartley, Executive Assistant II
		Gabriel Fernandez, Coordinator, Governance Services

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 Health (the "Committee") was called to order at 5:34 pm by Chair Carol Somersille. A verbal roll call was taken. Dr. Legha, Dr. Ho, and Melora Simon were absent at roll call. All other members were present at roll call and participated in person or telephonically. Melora Simon joined at 5:36 pm. A quorum was not present until Dr. Ho's arrival at 5:56 pm. No votes were taken before quorum was present.	
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	Ms. Hartley shared that two members of the Committee, Dr. Krutica Sharma and Mr. Pancho Chang, were participating remotely due to Just Cause. Chair Somersille asked both Dr. Sharma and Mr. Chang if there were any adults in the room. Both confirmed there were no adults present.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
4. PUBLIC COMMUNICATION	There were no comments from the public.	

5. CONSENT CALENDAR	*Agenda item 5 was revisited at 6:32 pm due to no quorum at the paced time.* Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. No items were pulled. **Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (06/05/2023), For information: (b) FY24 Pacing Plan, (c) QC Follow-Up Items **Movant**: Zoglin **Second**: Po **Ayes**: Somersille, Chang, Po, Ho, Sharma, Simon, Zoglin, Sharma **Noes**: None **Abstain**: None **Absent**: Legha **Recused**: None	***Consent Calendar Approved***
6. CHAIR'S REPORT	Chair Somersille discussed and outlined the primary goals for the upcoming year and emphasized that the committee's focus for the year will be a continuation of last year's objectives, with specific attention given to enhancing Patient Experience and addressing healthcare inequities within the District. She also noted the committee's commitment to developing an action plan with measurable objectives and timelines to guide their work toward achieving these significant goals.	
7. PATIENT STORY	Cheryl Reinking, CNO presented a patient story reported by an ECH employee regarding a recent patient incident involving failed translation services in a time of critical need. Staff attempted to call the language translation line and were unsuccessful in reaching a Japanese interpreter. This was very frustrating for the staff as well as very distressing for the family. The vendor who provides language translation service did not meet our needs in this situation. A meeting has occurred with the executive management from the vendor company, indicating the seriousness of this event, and the service standards expected. There is a plan to start a pilot utilizing iPad's with the translation service in every room in which the patient's primary language is not English. Ms. Simon asked Ms. Reinking how the staff follow-up was conducted. Ms. Reinking responded that she spoke personally with the ECH employee and relayed the actions taken to ensure that this issue does not persist. Ms. Reinking did note that this was an anomaly with the translation service.	

8. Q4 FY23 STEEEP DASHBOARD & FY23 ENTERPRISE QUALITY DASHBOARD	Dr. Holly Beeman, CQO presented on the Q4 FY23 STEEEP dashboard & FY23 Enterprise Quality dashboard: Dr. Beeman discussed that the STEEEP report is a quarterly dashboard created for the El Camino Hospital Board audience. It is a high-level snapshot of quality without trend lines or control charts. This is in contrast to the monthly Enterprise Quality, Safety, and Experience dashboard created for the Quality Committee and ECH management audiences. Ms. Simon expressed gratitude for the thoroughness of the memo provided in support of the STEEEP and Enterprise Quality dashboards. Mr. Chang asked for comments on patient experience results and what plans are in place in order to increase the number of dimensions of patient experience to foster a deeper understanding. Dr. Beeman clarified that many patient experience domains are tracked in granular detail via the Press Ganey survey. For the purposes of governance, three of these domains are reported in the dashboard. Mr. Chang also asked for comments on how Press Ganey is utilized and compared with other sources of feedback from our patients.	
9. EL CAMINO HEALTH MEDICAL NETWORK REPORT	Mr. Shahab Dadjou, Ms. Ute Burness, and Ms. Christine Cunningham provided a report on the quarterly update of ECHMN quality: There are three key areas of focus for ECHMN with respect to quality and service: Clinical Excellence, Dependable and Convenient Care, Patient Experience (Likelihood to Recommend (LTR), and Merit Base Incentive Payment System (MIPS). Ms. Burness reported that ECHMN had met their targets in five of the six measures they planned for in FY23. Ms. Burness expressed that the Quality Committee for ECHMN will be moving to collect data on a calendar year basis going forward. Ms. Cunningham described ECHMN patient experience results improvements all were prevalent in the FY23 Outcomes. Ms. Cunningham outlined the FY24 plan and goals. Chair Somersille asked for follow up for Bay Area and California comparisons and information on the statistical significance of the results.	***Follow-Up:*** *Local comparisons of the FY23 patient experience data as well as an outline of which data is statistically meaningful*
10. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 7:12 pm. **Movant**: Zoglin **Second**: Po **Ayes**: Somersille, Chang, Po, Ho, Sharma, Simon, Zoglin, Sharma **Noes**: None **Abstain**: None **Absent**: Legha **Recused**: None	***Adjourned to closed session at 7:12 pm***

11. AGENDA ITEM 16: RECONVENE OPEN SESSION/REPORT OUT	The open session reconvened at 7:22 pm. Agenda items 11-15 were addressed in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (06/05/2023), the Quality Council Minutes (06/07/2023), and the Credentialing and Privileges Report by unanimous vote by all committee members present.	
12. AGENDA ITEM 17: ROUNDTABLE	No comments were shared.	
13. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 7:29 pm **Movant**: Po **Second**: Chang **Ayes**: Somersille, Chang, Po, Ho, Sharma, Simon, Zoglin, Sharma **Noes**: None **Abstain**: None **Absent**: Legha **Recused**: None	***Adjourned at 7:29 pm***

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

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Gabriel Fernandez, Governance Services Coordinator

Prepared by: Gabriel Fernandez, Governance Services Coordinator
Reviewed by: Tracy Fowler, Director of Governance Services

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: September 5, 2023
Subject: Enterprise Quality, Safety and Experience Dashboard through July 2023

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety and experience measure performance through July 2023 (unless otherwise noted).

Summary:

Situation: The Fiscal Year 2024 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. As this is the first dashboard with our refreshed measures for FY24, you will see some new measures for the first time. We have a new HAC 2.0 Index, and, we have elevated hand hygiene and exclusive breast milk feeding to be tracked on our monthly Enterprise Quality, Safety and Experience Dashboard.

Assessment:

a) Quality Measures

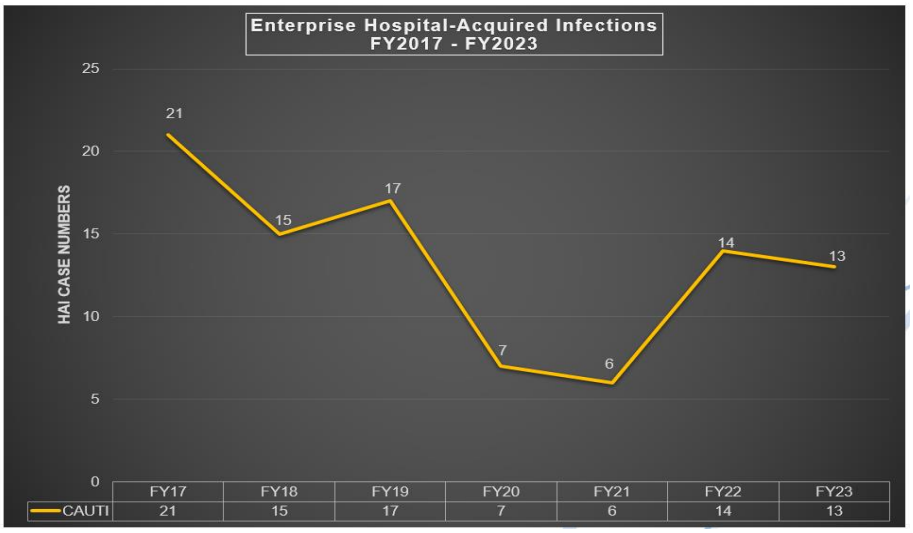
i) **Hospital Acquired Condition Index 2.0** (lower is better). This metric is a composite of the weighted rates of 4 component measures:

FY 24 HAC 2.0 weighting and targets			
Component	**Denominator**	**Weighting**	**Weighted Rate**
CLABSI	per 1,000 central line days	15%	aa
CAUTI	per 1,000 Foley catheter days	15%	bb
C. Diff	per 10,000 patient days	35%	cc
nvHAP	per 1,000 patient days	35%	dd
		SUM	HAC Index

HAC 2.0 Index for July is 2.3 (greater) than target of 1.864. This is driven in large part due to the 4 catheter associated urinary tract infections in July.

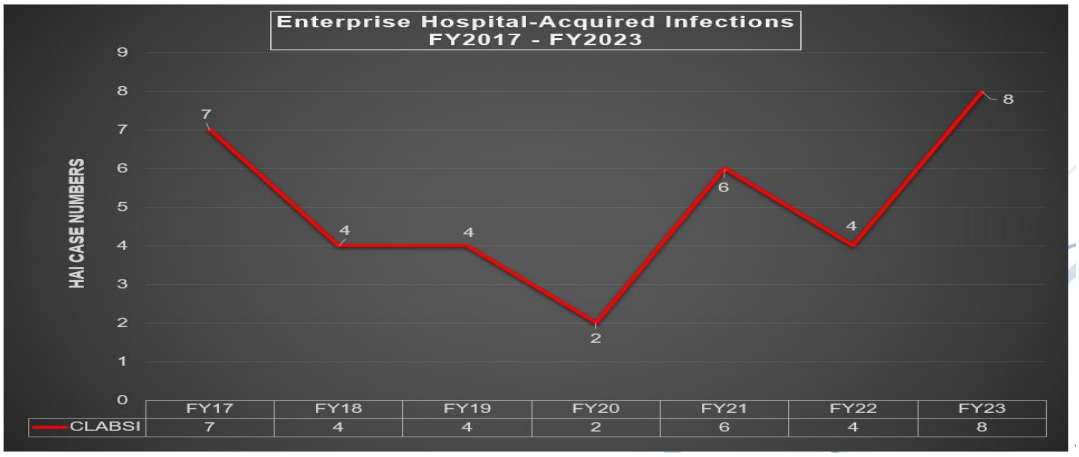
1. C. Difficile Infection (C. Diff). Of the three hospital acquired C. Difficile infections in July, all three were non-preventable and care and testing were appropriate.
2. Catheter Associated Urinary Tract Infection (CAUTI). This is a new measure for the dashboard for FY24 and is one of four components making up the HAC 2.0 Index. In the way of background, patients who experience a catheter-associated urinary tract infection have between 1-13% excess mortality and on average 2 weeks of extra length of stay (Alsaffar, 2023). We

are including CAUTI as a focused quality measure in FY24 because of the trends in FY22 and FY23 in which our CAUTI events increased.



We are concerned that four patients experienced a CAUTI in July 2023. This is higher # infections per month than the prior 12 months. Our CAUTI process improvement team is focused on; 1. Optimizing nurse standard procedure for discontinuation of Foley catheter without requiring a physician's order. 2. Debriefing on feedback and education completed during the Bard Catheter Vendor on site observations and recommendations. 3. Transitioning to non-invasive bladder drainage alternatives such as the male and female pure-wick devices, which do not require introducing a catheter through the urethra into the urinary bladder.

3. Central Line Associated Blood Stream Infection (CLABSI). This is a new measure for the dashboard for FY24 and is one of four components making up the HAC 2.0 Index. In the way of background, patients who experience a CLABSI have between 5% and 30% excess mortality and on average 2 weeks of extra length of stay (Alsaffar, 2023). The CLABSI rate trend at ECH over the past two years resembles the national and international trend in



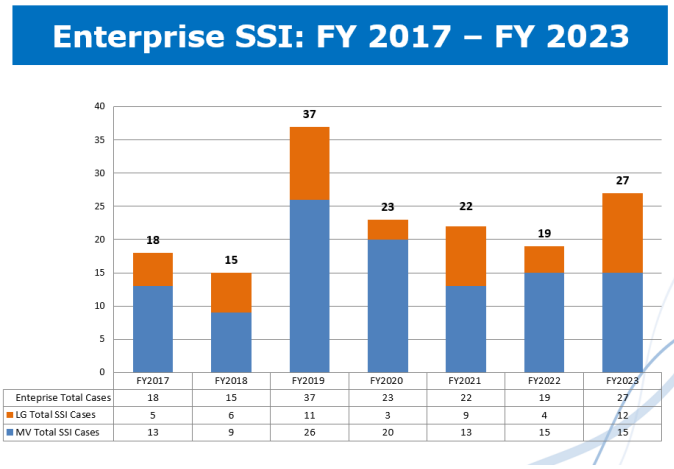
CLABSI rates. Nationally, CLABSI rates have increased by 51% compared to pre-pandemic (Fakih, 2021).

There were no CLABSI infections in July 2023. Improvement/maintenance efforts are focused on creating and disseminating standard procedures for central line dressing care.

4. Non-ventilator Hospital Acquired Pneumonia (nvHAP). This quality measure is again included in the HAC Index. We are collaborating with a leading expert in nvHAP prevention, Dr. Dian Baker (Baker, 2021). Dr. Baker has been on campus in August providing education and guidance to our nvHAP and education teams. Our primary focus is on adopting and spreading a standard for oral hygiene compliance, and, documentation.

ii) Hand Hygiene Compliance. This is a new measure for the FY24 Quality Dashboard. Secret shoppers are deployed throughout the hospital to observe handwashing compliance when team members enter and exit a patient's room. The trend in July 2023 shows a sharp decline. This is attributed to a decrease in the volume of observations completed during the month of July, and, lack of attention to following our policies around infection prevention practices. Regardless, focused attention on maintaining the improvement observed in FY23 because of the robust hand hygiene campaign is a top priority. We are in the process of overhauling and enhancing our hand hygiene program. The LEAPFROG standards for hand hygiene compliance are now significantly increased. This is likely a result of the significant uptick in hospital-acquired infections in the past two years, being in part, attributed to a deterioration nationwide in hand hygiene compliance. With new staff, travelers and a volatile workforce in all hospital departments, the need to focus on back to basics remains paramount to our success in reducing hospital-acquired infections.

iii) Surgical Site Infections. We will continue to track and make visible our surgical site infection performance. In the last half of FY23, we experienced an unusual and unexpected uptick in total knee replacement joint infections. There were nine total knee replacement (TKR) infections compared to prior years when there were 2-3 per year. This has been described in previous Quality Committee memos and meetings. We have a multidisciplinary Knee SSI Reduction Task Force focused on four top areas of opportunity;



1. Decreasing traffic in and out of the OR during cases. 2. Standardizing surgeon irrigation technique of the joint space. 3. Decreasing possibility of hair and skin contaminating the sterile instruments or field by enforcing surgical attire standards for all team members, including vendors, who enter the operating suite. 4. Improving sterile processing department performance, which contributes to OR traffic if not all instruments required, are present and usable at the start of the case.

iv) Readmission Index. Performance in June 2023 is 1.13. There are no material system changes in our processes to suggest this is a trend.

v) Mortality Index and Sepsis Index trend together. We are encouraged to see improved (lower) Sepsis Mortality Index and attribute this to better alignment and role clarity with our new ED leadership team for our patients with Sepsis who are boarding in the ED.

vi) PC-02 Cesarean Birth. No new data to report.

vii) PC-05: Exclusive Breast Milk Feeding. This is a new measure on our FY24 Quality Dashboard.

> *"Breastfeeding provides unmatched health benefits for babies and mothers. It is the clinical gold standard for infant feeding and nutrition, with breast milk uniquely tailored to meet the health needs of a growing baby. We must do more to create supportive and safe environments for mothers who choose to breastfeed."*
>
> Dr. Ruth Petersen, director of CDC's Division of Nutrition, Physical Activity, and Obesity

b) Patient Experience Measures

i) Patient experience measures in all four domains reported on the Quality Dashboard are favorable and exceeding target for month of July 2023!

References

Alsaffar, M. J. (2023). Impact of COVID-19 pandemic on rates of central line-associated bloodstream infection and catheter-associated urinary tract infection in an intensive care setting: National experience. *American Journal of Infection Control*.

Baker, D. (2021). Nonventilator hospital-acquired pneuomonia: A call to action. *Infection Control and Hospital Epidemiology*.

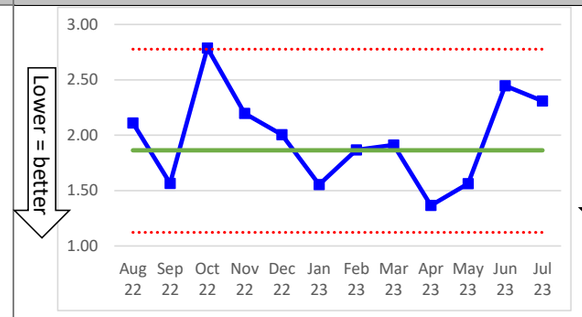
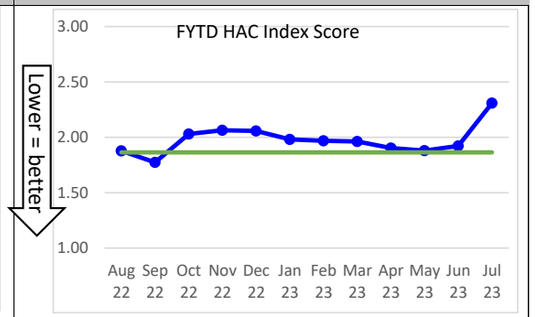
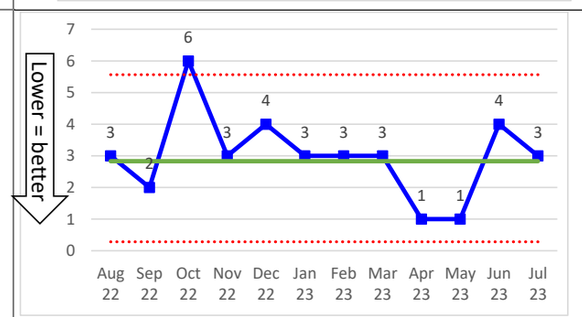
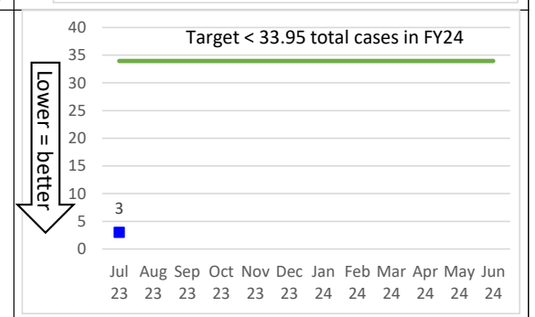
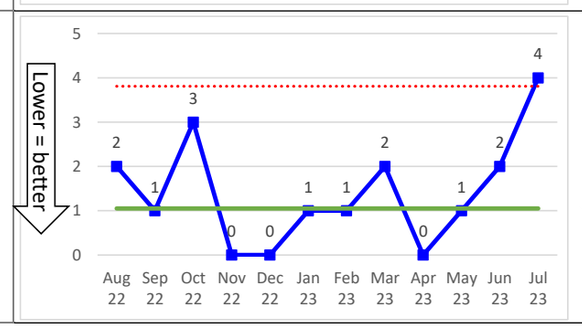
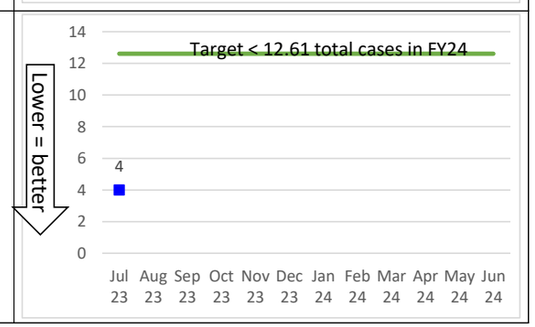
Fakih, M. G. (2021). Coronavirus disease 2019 (COVID-19) pandemic, central-line-associated bloodstream infection (CLABSI), and catheter-associated urinary tract infection (CAUTI): The urgent need to refocus on hardwiring prevention efforts. *Infection Control & Hospital Epidemiology* .

El Camino Health

FY24 Enterprise Quality, Safety, and Experience Dashboard

July 2023 (unless otherwise specified)

Month to Board Quality Committee:
September, 2023

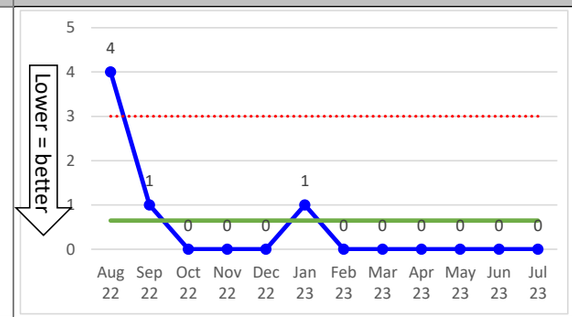
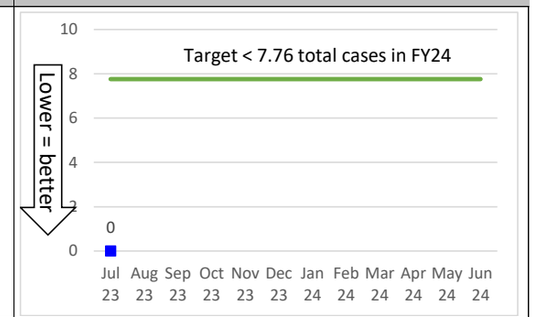
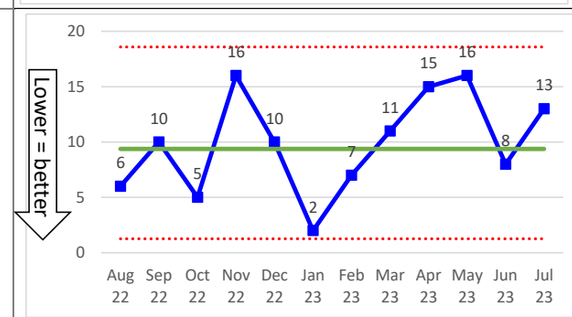
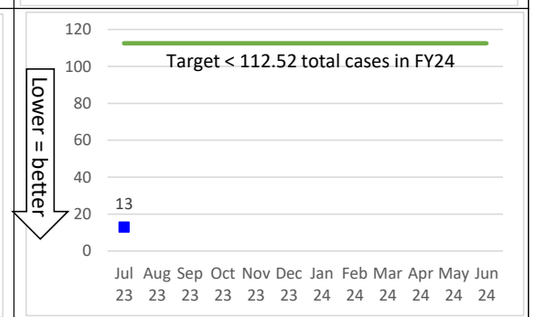
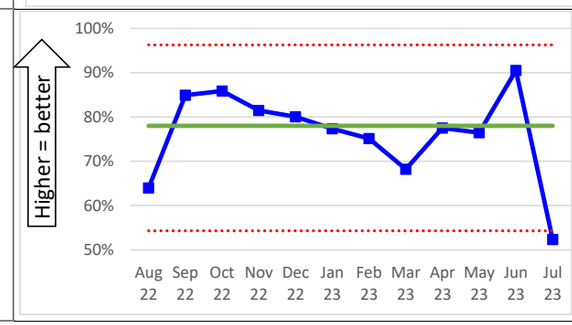
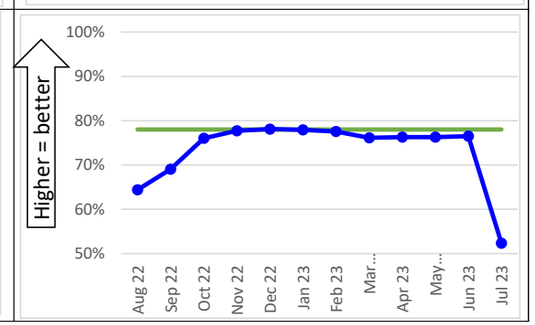
		FY24 Performance		Baseline FY23 Actual	FY 24 Target	Month Trend (showing last 12 months of data)	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **HAC Index 2.0** *Latest data month: July 2023*	2.309	2.309	1.921	1.864 (3.0% ↓)		
2	**HAC component** **Clostridium Difficile Infections (C-Diff)** *Latest data month: July 2023*	3 cases	3 cases / mo	2.92 cases / mo	2.83 cases / mo		
3	**HAC component** **Catheter Associated Urinary Tract Infection (CAUTI)** *Latest data month: July 2023*	4 cases	4 cases / mo	1.08 cases / mo	1.05 cases / mo		

El Camino Health

FY24 Enterprise Quality, Safety, and Experience Dashboard

July 2023 (unless otherwise specified)

Month to Board Quality Committee:
September, 2023

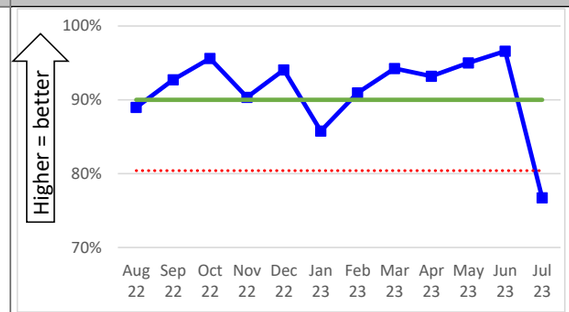
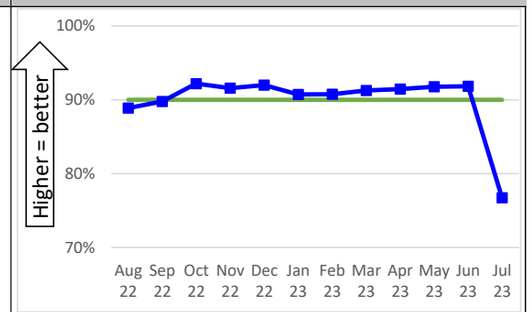
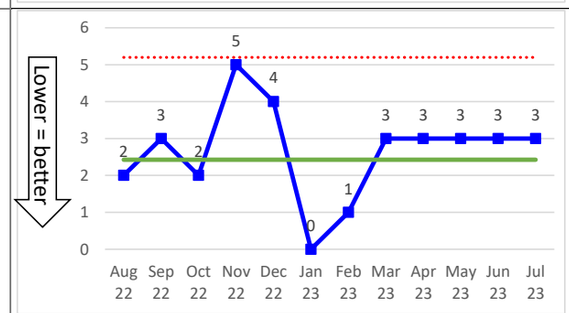
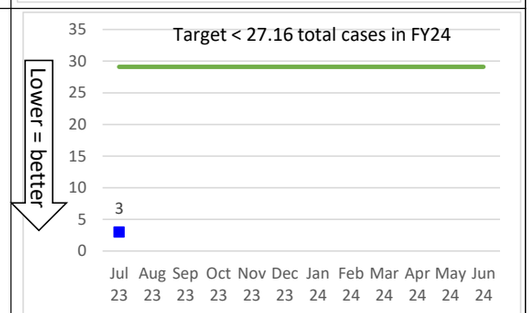
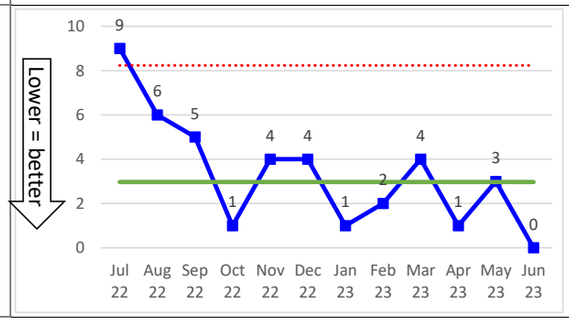
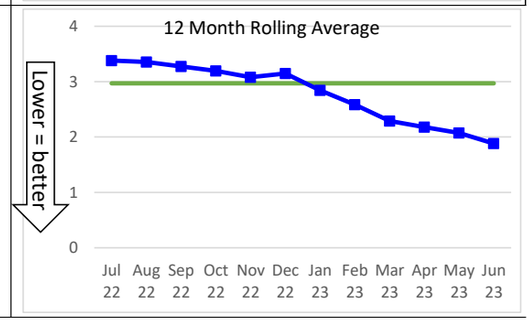
		FY24 Performance		Baseline FY23 Actual	FY 24 Target	Month Trend (showing last 12 months of data)	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
4	**HAC component** **Central Line Associated Blood Stream Infection (CLABSI)** *Latest data month: July 2023*	0 cases	0 cases / mo	0.67 cases / mo	0.65 cases / mo		
5	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: July 2023*	13 cases	13 cases / mo	9.67 cases / mo	9.38 cases / mo		
6	**Hand Hygiene Compliance (Entry) %** *Latest data month: July 2023*	52.4%	52.4%	76.5%	78.0%		

El Camino Health

FY24 Enterprise Quality, Safety, and Experience Dashboard

July 2023 (unless otherwise specified)

Month to Board Quality Committee:
September, 2023

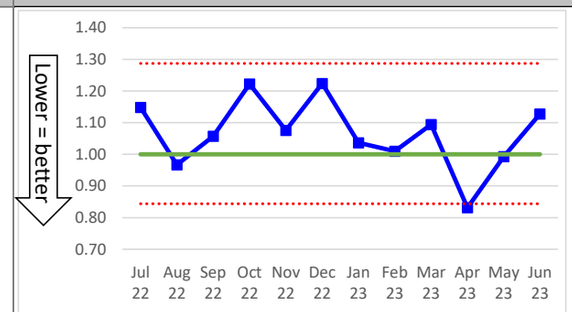
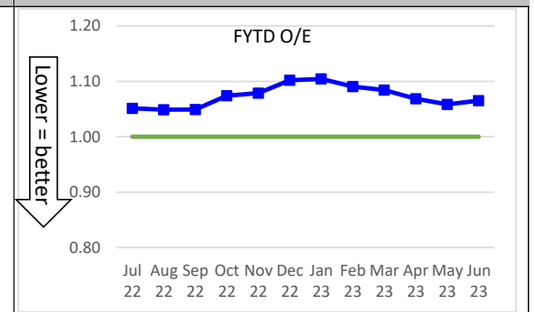
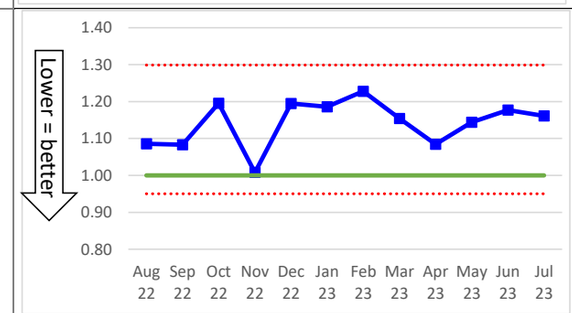
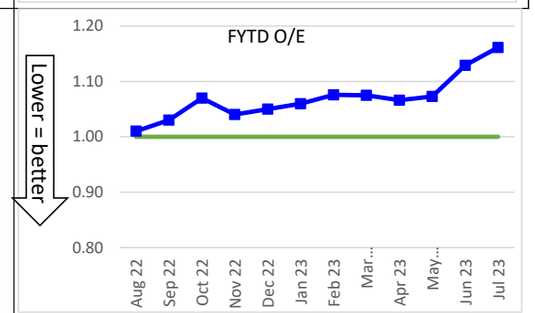
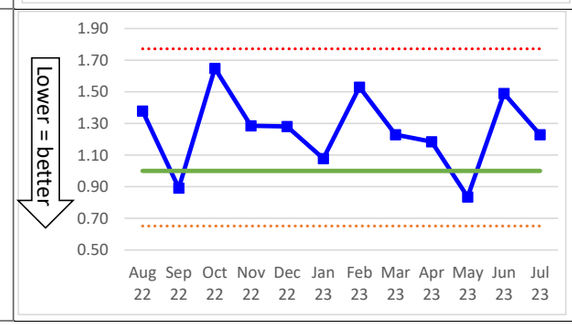
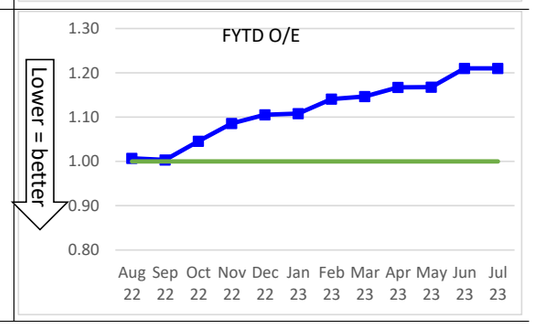
		FY24 Performance		Baseline FY23 Actual	FY 24 Target	Month Trend (showing last 12 months of data)	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
7	**Hand Hygiene Compliance (Exit) %** *Latest data month: July 2023*	76.7%	76.7%	91.8%	90.0%		
8	**Surgical Site Infections (SSI)** *Latest data month: July 2023*	3 cases	3 cases / mo	2.5 cases / mo	2.43 cases / mo		
9	**Serious Safety Event Rate (SSER)** **Latest data month:* ***June 2023***	0 events	1.88 (40/212460)	1.88 (40/212460)	2.97		

El Camino Health

FY24 Enterprise Quality, Safety, and Experience Dashboard

July 2023 (unless otherwise specified)

Month to Board Quality Committee:
September, 2023

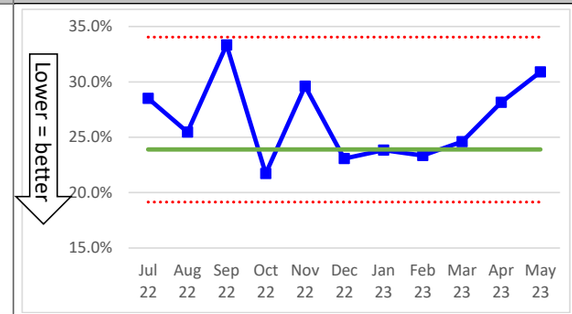
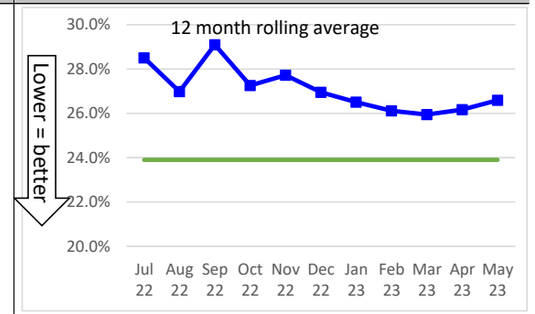
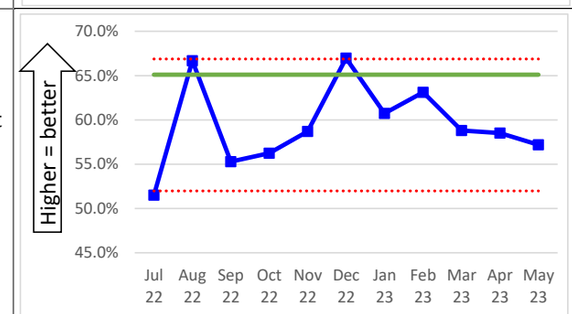
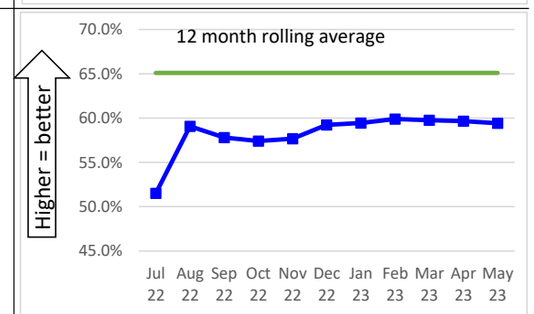
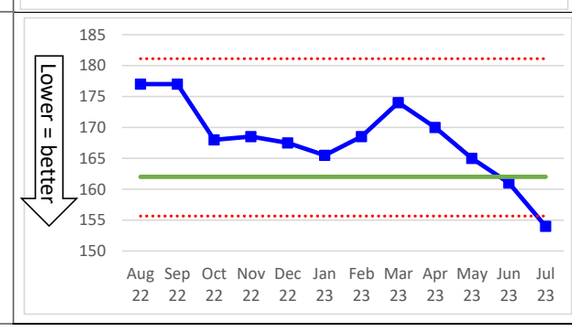
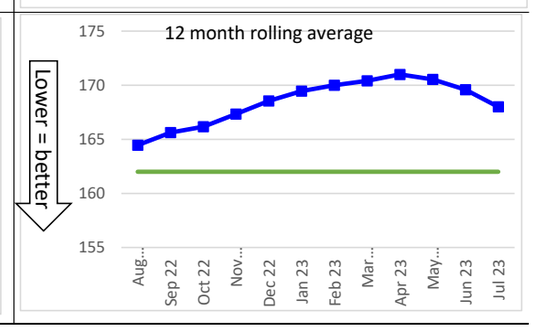
		FY24 Performance		Baseline FY23 Actual	FY 24 Target	Month Trend (showing last 12 months of data)	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
10	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** ** Latest data month:* ***June 2023***	1.13 (8.70%/7.72%)	1.07 (8.47%/7.94%)	1.07 (8.47%/7.94%)	1.00		
11	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: July 2023*	1.16 (1.88%/1.62%)	1.16 (1.88%/1.62%)	1.13 (2.21%/1.96%)	1.00		
12	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: July 2023*	1.23 (11.90%/9.68%)	1.23 (11.90%/9.68%)	1.21 (14.07%/11.59%)	1.00		

El Camino Health

FY24 Enterprise Quality, Safety, and Experience Dashboard

July 2023 (unless otherwise specified)

Month to Board Quality Committee:
September, 2023

		FY24 Performance		Baseline FY23 Actual	FY 24 Target	Month Trend (showing last 12 months of data)	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
13	**PC-02: Cesarean Birth** *Latest data month:* ***May 2023***	MV : 31.9% (44/138) LG : 25.9% (7/27) ENT : 30.9% (51/165)	MV : 27.8% (481/1733) LG : 19.5% (58/297) ENT : 26.6% (539/2030)	MV : 27.8% (481/1733) LG : 19.5% (58/297) ENT : 26.6% (539/2030)	23.9% (FY24 Target)		
14	**PC-05: Exclusive Breast Milk Feeding** **Latest data month:* ***May 2023***	MV : 53.5% (147/275) LG : 74.6% (44/59) ENT : 57.2% (191/334)	MV : 57.8% (1792/3103) LG : 67.8% (398/587) ENT : 59.3% (2190/3690)	MV : 57.8% (1792/3103) LG : 67.8% (398/587) ENT : 59.3% (2190/3690)	ENT/MV Target 65.1% LG Target 70.0%		
15	**Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: July 2023*	MV : 175 mins LG : 133 mins ENT : 154 mins	MV : 175 mins LG : 133 mins ENT : 154 mins	MV : 197 mins LG : 142 mins ENT : 170 mins	MV : 191 mins LG : 133 mins ENT : 162 mins		

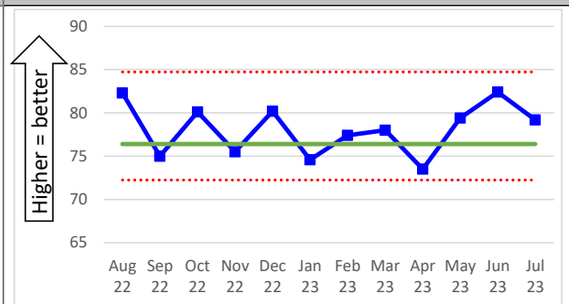
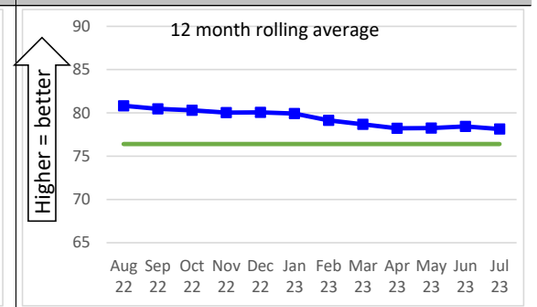
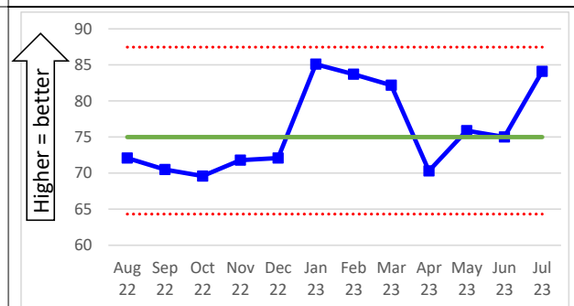
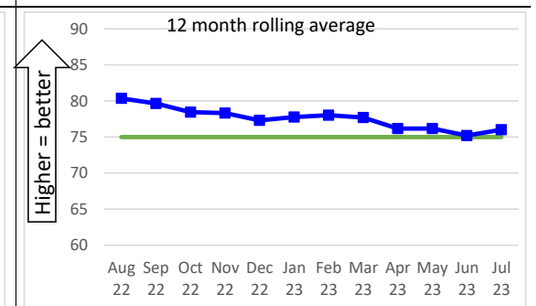
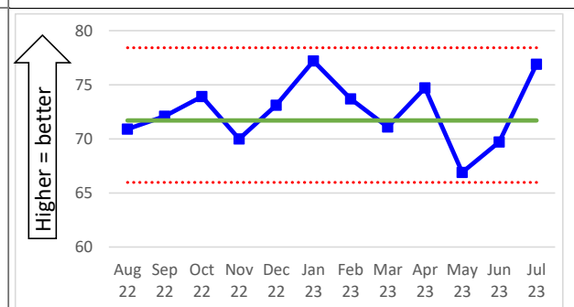
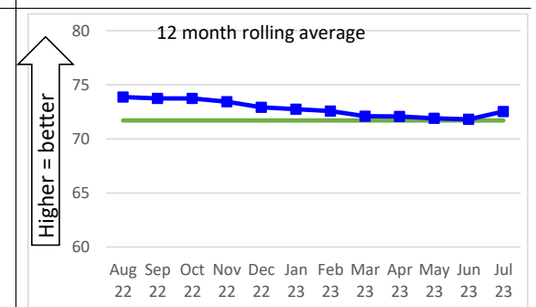
El Camino Health

FY24 Enterprise Quality, Safety, and Experience Dashboard

July 2023 (unless otherwise specified)

Month to Board Quality Committee:

September, 2023

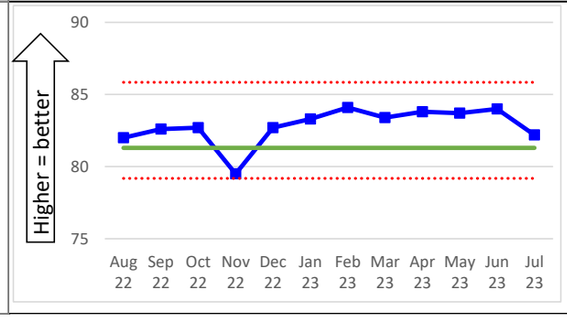
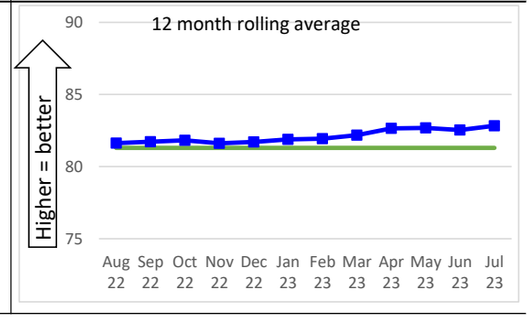
		FY24 Performance		Baseline FY23 Actual	FY 24 Target	Month Trend (showing last 12 months of data)	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
16	*Organizational Goal **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: July 2023*	79.2	79.2	78.5	76.4		
17	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: July 2023*	84.1	84.1	75.0	75.0		
18	**ED Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: July 2023*	76.9	76.9	71.7	71.7		

El Camino Health

FY24 Enterprise Quality, Safety, and Experience Dashboard

July 2023 (unless otherwise specified)

Month to Board Quality Committee:
September, 2023

		FY24 Performance		Baseline FY23 Actual	FY 24 Target	Month Trend (showing last 12 months of data)	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
19	* Organizational Goal **ECHMN (El Camino Health Medical Network) : Likelihood to Recommend Clinic** **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Adjusted** *Latest data month: July 2023*	82.2	82.2	82.7	81.3		

Notes:

1) SSER through June 2023
2) Readmissions through June 2023
3) PC-02 & PC-05 through May 2023
4) Updated 8/28/23

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
1	*Organizational Goal **HAC Index 2.0** *Latest data month: July 2023*		H. Beeman, MD	For Fy24, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (4) key inpatient safety events. The elements of the composite are weighted as noted: Clostridium difficile infections (C-Diff) 35%, Catheter Associated Urinary Tract Infection (CAUTI) 15%,Central Line Associated Blood Stream Infection (CLABSI) 15%, and non-ventilator hospital-acquired pneumonia (nvHAP) 35%,	See below
2	HAC component **Clostridium Difficile Infections (C-Diff)** *Latest data month: July 2023*		C. Nalesnik	1) Based on NHSN defined criteria: inclusions: Inpatients, Peri-Op, Behavioral Health; exclusions: Rehab, NICU, outpatients, ED patients 2) All positive C.diff Toxin/antigen lab tests that result on or after the patient's 4th day of hospitalization 3) Latency: C-Diff infections may be identified up to 30 days, thus previously reported results may change.	Numerator: Infection control Dept. Denominator: EPIC Report
3	HAC component **Catheter Associated Urinary Tract Infection (CAUTI)** *Latest data month: July 2023*		C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	Numerator: Infection control Dept. Denominator: EPIC Report

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
4	**HAC component** **Central Line Associated Blood Stream Infection (CLABSI)** *Latest data month: July 2023*		C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	Numerator: Infection control Dept. Denominator: EPIC Report
5	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: July 2023*		C. Delogramatic	1) Internal metric: Inpatient non-ventilator hospital-acquired pneumonia cases. 2) Numerator inclusions: inpatients (18+yrs) w/ a specified pneumonia diagnosis code(s) with POA (present on admission) status of "N" (acquired during the hospital encounter), that is unrelated to mechanical ventilation; monthly, cases are reviewed & confirmed by the nvHAP workgroup. 3) Denominator EPSI patient days excluding 6070 NICU/Nursery Lvl 2, 6310/6315 MBU, 6340 Behavioral Health, 6440 IP Rehab, 6900 Pre-Op SSU, 7400 L&D, 7427 PACU 5) Latency: periodic; corrections may change previously reported results.	EPIC Clarity data warehouse; Numerator identified by nvHAP workgroup; Denominator: EPSi patient days
6	**Hand Hygiene Compliance (Entry) %** *Latest data month: July 2023*		Ann Aquino	Hand hygiene observations by dedicate staff or secret shopper. One entry or one exist observation will count as one observation. For C.Diff room, staff needs to use soap and water at exist to consider hand hygiene compliance.	Observation recorded in Vocera or on Paper

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
7	**Hand Hygiene Compliance (Exit) %** *Latest data month: July 2023*		Ann Aquino	Hand hygiene observations by dedicate staff or secret shopper. One entry or one exist observation will count as one observation. For C.Diff room, staff needs to use soap and water at exist to consider hand hygiene compliance.	Observation recorded in Vocera or on Paper
8	**Surgical Site Infections (SSI)** *Latest data month: July 2023*		C. Nalesnik	1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty". 4) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. 5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.	Numerator: Infection control Dept. Denominator: EPIC Report
9	**Serious Safety Event Rate (SSER)** **Latest data month:* ***June 2023***		S. Shah	1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. 2) Inclusions: events determined to be serious safety events per Safety Event Classification team 3) NOTE: the count of SSE HAPIs MAY differ from internally-tracked HAPIs 4) Denominator: EPSI Acute Adjusted Patient Days For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero. New classification rules in effect as of 7/1/22	HPI Systems

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
10	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** ** Latest data month:* ***June 2023***		H. Beeman, MD	1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause). 2) Based upon Premier's Care Sciences Standard Practice risk-adjustment + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient 4) NOTE: Excludes cases discharged from (1) hospital, then readmitted to the other hospital w/in 30D. For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Premier Quality Advisor
11	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: July 2023*		H. Beeman, MD	1) Based upon Premier's Care Sciences Standard Practice RA for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient; exclusions: Patient Type = Rehab, Psychiatric or Hospice. For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= to zero.	Premier Quality Advisor
12	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: July 2023*		J. Harkey, H. Beeman, MD	1) Numerator inclusions: Patient Type = Inpatient, Prin or 2nd diagnosis of sepsis & age 18+ yrs 2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB) For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Premier Quality Advisor

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
13	**PC-02: Cesarean Birth** *Latest data month:* ***May 2023***		Heather Freeman	1) Numerator: Patients with cesarean births 2) Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	CMQCC
14	**PC-05: Exclusive Breast Milk Feeding** **Latest data month:* ***May 2023***		Heather Freeman	1) Numerator: Newborns that were fed breast milk only since birth 2) Denominator: Single term newborns discharged alive from the hospital	CMQCC
15	**Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: July 2023*		J. Baluom	ED Arrival to ED Departure (TAT-D - Direct Discharge): This metric is the median arrival to patient discharged time from ED. This metric excludes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery Patients who arrive via the ED. **Time stamp is used for this calculation:** ED Arrival - Patient Arrived in ED (50) (ADT_ARRIVAL_DTTM in Clarity "F_ED_ENCOUNTERS" table) ED Departure Time - "ED_Departure_DTTM" in Clarity "F_ED_ENCOUNTERS" table	EDSBAR Tableau Dashboard; EDOC Monthly Meeting Dashboard

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
16	*Organizational Goal **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: July 2023*		C. Cunningham	1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. 2) Inclusions: Inpatient nursing units; excludes: MBU. 3) Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS
17	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: July 2023*		C. Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS
18	**ED Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: July 2023*		C. Cunningham	ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted' For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
19	*** Organizational Goal** **ECHMN (El Camino Health Medical Network) : Likelihood to Recommend Clinic** **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Adjusted** *Latest data month: July 2023*		C. Cunningham	Switched Vendor NRC to PressGaney in January 2022. Started reporting in FY 23 dashboards 'Top Box, Received Date, and Unadjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey

Notes:

1) SSER through June 2023

2) Readmissions through June 2023

3) PC-02 & PC-05 through May 2023

4) Updated 8/28/23

El Camino Health

FY24 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: Chiefs/Vice Chiefs of the Medical Staff, physicians, nurses, and members from the community advisory councils, or the community at-large.

GOALS	TIMELINE	METRICS
1. Ensure the metrics included on the Quality Committee dashboards (Enterprise Quality, Patient Care and Patient Experience dashboard, and STEEEP) are in alignment with the enterprise strategic plan.	Q4FY23 review and update which measures to include on the FY24 quarterly board STEEEP report.	- Enterprise quality dashboard measures and targets - STEEEP dashboard measures and targets.
2. Monitor Quality, Patient Care and Patient Experience performance in accordance with the pacing plan to track progress towards achieving targets.	Q4FY23, review FY24 Incentive Goal recommendations for Quality, Safety and Patient Experience measures and targets.	- Monthly Enterprise dashboard measures with targets and performance - Quarterly STEEEP dashboard with targets and performance
3. Identify and reduce health care disparities for ECH patients.	Biannual report to Quality Committee FY24.	- Monitor the effectiveness of ECH activities to reduce health care disparities in the individuals we serve
4. Foster a culture of collaboration, transparency, and continuous improvement within the Quality Committee by implementing regular feedback mechanisms, encouraging open communication, and promoting a shared sense of responsibility for achieving quality outcomes.	Using closing wrap up time, review quarterly at the end of the meeting.	- Attend a minimum of 7 meetings in person - Actively participate in discussions at each meeting - Improvement on baseline metrics for the assessment (Initial assessment to be conducted prior to the beginning of FY24)
5. Participate in the training and development of the Committee.		- Attend a conference and/or session with a subject matter expert - Commit to ongoing learning as needed.

Chair: Carol Somersille, MD
Executive Sponsor: Holly Beeman, MD, MBA, Chief Quality Officer

As of: 08/29/23

Quality Committee Follow-Up Items

Item	Date Requested	Committee Member Name	Item Requested	Individual to complete the follow up	Completion Date
			FY23		
1	9/6/2022	Carol Somersille, MD	4d – Progress Against FY23 Committee Goals. She noted to correct the Chair name to her name and remove Julie Kliger's name.	Nicole Hartley	9/7/2022
2	9/6/2022	Carol Somersille, MD	item dated 06/06/2022 to her name and remove Holly Beeman's name under Committee Member.	Nicole Hartley	9/7/2022
3	11/7/2022	John Zoglin	Agenda Item 7. Follow up items are: Present a 5-year analysis to the Committee and a status update on the deciles.	Nicole Hartley/Christine Cunningham	12/12/2022
4	11/7/2022	Alyson Falwell	stroke patients evaluated and discharged from ED) performance as shared in Core Measure report during the Nov 2022 Quality Committee Meeting.	Dr. Holly Beeman	12/12/2022
5	11/7/2022	Melora Simon	Requests to display both the fiscal year to date and rolling 12 month performance results in future ECHMN quality reports.	Ute Burness	2/6/2023
6	2/6/2023	Krutica Sharma, MD	Requested that we add a monthly threshold or target line to the trend chart on the Enterprise Dashboard	Dr. Holly Beeman	3/6/2023
7	2/6/2023	Krutica Sharma, MD	Request the action plan for complying with the new Joint Commission patient safety goal regarding Health Equity be shared with the committee at a future meeting.	Dr. Holly Beeman	6/5/2023
8	3/6/2023	Melora Simon	Deep Dive on emergency department times and throughput at a future meeting.	Dr. Meenesh Bhimani/Cheryl Reinking	5/1/2023
9	4/3/2023	John Zoglin	Enterprise Quality Dashboard: Dr. Beeman to work with MCH on a timely measure.	Dr. Holly Beeman	
10	4/3/2023	John Zoglin, Melora Simon, Krutica Sharma	FY24 Committee Goals: Initial committee assessment and updated FY24 Goals to be shared with QC at the May meeting by Tracy.	Tracy Fowler	5/1/2023
11	4/3/2023	Melora Simon	**CLOSED SESSION ITEM:** Dr. Beeman will share RCA details at the May meeting from the March Serious Safety/Red Alert Event.	Dr. Holly Beeman	5/1/2023
12	6/5/2023	Krutica Sharma, MD	Share Patient Fall rate with harm at next meeting.	Dr. Holly Beeman	8/7/2023
13	6/5/2023	Krutica Sharma, MD	Add language to reflect the Quality Committee's oversight in the QAPI plan.	Dr. Holly Beeman	6/6/2023
			FY24		
1	8/7/2023	Carol Somersille, MD	Local comparisons of the FY23 patient experience data as well as an outline of which data is statistically meaningful	Christine Cunningham	9/5/2023

<u>September 5th, 2023 Quality, Experience and Safety Committee Meeting</u>

Quality Committee Follow Up Item: El Camino Health Medical Network (ECHMN) Patient Experience

Background: During the August 7, 2023 Board Quality Safety and Experience Committee, Christine Cunningham shared information about ECHMN patient experience performance. Committee members requested additional information on:

1. Likelihood to recommend (LTR) performance compared to national, California and Bay Area comparators.
2. What targets would ECHMN need to achieve for the improvement to be statistically significant?

Follow-Up Item #1—ECHMN LTR

Service Comparison Final FY23

SERVICE
Exceptional Personalized Experience, Always

Metric	FY23	PERCENTILE RANKING		
		NATIONALLY	CALIFORNIA	BAY AREA
LTR Clinic – ECHMN (All)	80.7	27	34	30

Follow-Up Item #2-Statistical significance of target

FY24 Inpatient LTR Target Based on BOD approved Methodology

FY23 Baseline	Min	Target	Stretch	Statistical Significance
78.5 80%ile	74.7 72%ile	76.4 76%ile (-2.10)	78.1 80%ile (-0.44)	80.9 (85%ile)

FY24 ECHMN LTR Clinic Target based on BOD approved Methodology

FY23 Baseline	Min	Target	Stretch	Statistical Significance
80.7 27%ile	80.0 17%ile	81.3 32%ile (+.58)	82.6 39%ile (+1.93)	81.8 (32%ile)

	Period/Response 1		Period/Response 2				
Question	*Number of Responses*	*Top Box % (p1)*	*Number of Responses*	*Top Box % (p2)*	*p2 - p1*	*Proportion*	*Z*
DATA HERE							
IP LTR	2177	78.5%	2177	80.9%	2.4%	0.797	1.97
ECHMN All	10017	80.7%	10017	81.8%	1.1%	0.813	1.99

Key
|z| > 1.96 : *p* <.05
|z| > 2.58 : *p* <.01

Significant at the .01 level
Significant at the .05 level
Not significant at either level

Number of Responses = n size for the total number of respondents to the item, not n size for top box

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: Tracy Fowler, Director of Governance Services
Date: September 5, 2023
Subject: Quality Committee Education Opportunities

Purpose:

To notify the Committee of potential education opportunities for FY24.

Summary:

FY24 Goal #5 for our committee is centered around our active participation in training and development initiatives. To measure our commitment to this goal, we've chosen specific metrics: attendance at conferences or sessions led by subject matter experts, coupled with a broader commitment to ongoing learning as needs arise.

We maintain a comprehensive calendar of conferences within the Boardvantage dashboard. In this memo we want to specially highlight certain events that align closely with our committee's focus. Below are three select conferences with an emphasis on quality and patient experience.

1. Hospital Quality Institute Annual Conference Oct 15-16 2023 in Lake Tahoe Area 2023 HQI and Hospital Council Annual Conference - HQI

2. Institute for Healthcare Improvement Forum, December 10-13, Orlando Florida IHI Forum | IHI - Institute for Healthcare Improvement

3. Press Ganey's Human Experience (HX) Conference, February 5-7, 2024 Orlando, FL https://www.pressganey.com/event/hx-2024/

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: September 5, 2023
Subject: Patient Story from ECHMN

Purpose: To provide the Committee with a patient story demonstrating continuity of care across the continuum of care within El Camino Health.

Summary:

1. Situation: This story provided by the ECHMN team describes a patient's clinical case that spanned care at the urgent care location to the MV Emergency Department.

2. Authority: To provide insight into a clinical scenario at El Camino Health and recognize the importance of cross continuum collaboration.

3. Background: As indicated in the patient story, the patient had received multiple telehealth visits and the patient's condition was not improving after suggested treatments. The patient arrived at the urgent care and the clinician/provider immediately recognized the significance of the patient's condition and made the referral to the MV Emergency Department.

4. Assessment: In accordance with the efforts to develop a systems approach to care between all the ECH sites of care, this case illustrates that collaboration is essential to address the immediate need for timely, efficient, and effective diagnosis and subsequent treatment. The patient was seen immediately in the MV ED and was admitted and treatment started. Although the treatment began at ECH, for severe cases of this condition, the burn center is often required for subsequent treatment. This patient's case was severe and was similar to a burn victim's presentation. Therefore, specialized skin treatments can be provided at burn centers which is what prompted this patient to be transferred to Valley Medical Center's burn unit.

5. Other Reviews: None

6. Outcomes: This case illustrates one case of collaboration amongst the ECH entities. The teams continue to work together to ensure that transfer of care is frictionless and transparent.

7. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. What are other ways the system promotes continuity of care amongst the different sites of care?

2. What systems are in place to promote continuity across the continuum?

ECHMN Patient Story

On 8/19/23, A 26 year old male visited the First Street Urgent Care Center. The patient complained of chills, sweats, fever and fatigue for 6 days. He had a rash with red spots all over his body. His blood pressure was 89/56 (low) with a pulse of 101 (high) and O2 saturation of 95% (low). He stated that he had been unable to drink water or eat food.

He had previously had two (2) telemedicine calls on 8/16 and 8/17 with Stanford Express Care. During those calls, he was diagnosed with hand, foot and mouth disease. They prescribed some creams to him to apply to the rash. The First Street Urgent care staff knew immediately that his symptoms were significant and needed a higher level of care.

The First Street Urgent Care staff promptly referred the patient to the El Camino Hospital Mountain View Emergency Department. The continuum of care was supported by the electronic health record. The ED staff and physicians were able to see all the information about the care the patient had received prior to his arrive to the ED—promoting a system of care across two locations of El Camino Health with a smooth transfer of information.

The patient was admitted to El Camino Hospital where his diagnosed with Stevens-Johnson syndrome/toxic epidermal necrolysis, acute kidney Injury, elevated liver function tests and lactate. On 8/21/23, the patient was transferred to the VMC burn unit which is appropriate for his condition, as the rash was over 65% of the patient's body. As of 8/23, he remains at VMC receiving care. Stevens-Johnson syndrome (SJS) is a rare, serious disorder of the skin and mucous membranes. It's usually a reaction to medication that starts with flu-like symptoms, followed by a painful rash that spreads and blisters. Then the top layer of affected skin dies, sheds and begins to heal after several days. Treatment focuses on removing the cause, caring for wounds, controlling pain and minimizing complications as skin regrows. It can take weeks to months to recover.

Thanks to the rapid evaluation and subsequent treatment of this patient at El Camino Health facilities, this patient received care and treatment and will recover from this illness.

El Camino Health

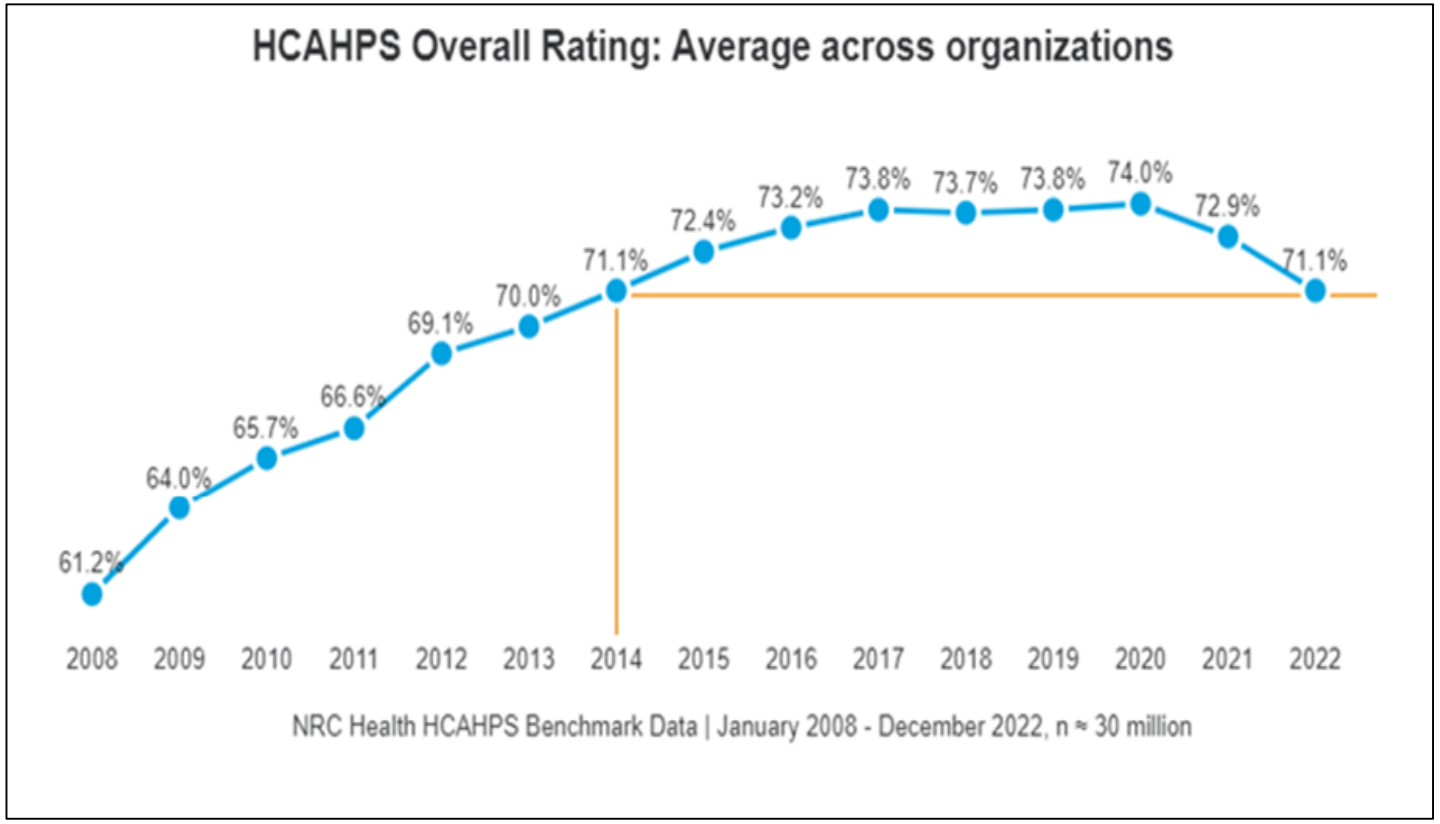
Quality Committee
Patient Experience Update
September 5, 2023

Christine L. Cunningham, CPXP, MBA

“Setting the standrd for the best healthcare experience in the Bay Area by delivering dependable clinical excellence in a caring, convenient way”

Patient Experience National Trends

Nationally, overall patient experience scores have decreased post COVID



- In 2022, the national average overall patient experience rating dropped to **71.1%,** a level not seen since 2014
- National trend attributed to:
  - Increased patient complexity from delays in seeking care
  - Workforce shortages from the “Great Resignation”
  - Increased use of temporary staff
  - Visitor restriction policies
  - Shifted focus toward pure clinical care and COVID exposure reduction versus overall patient experience

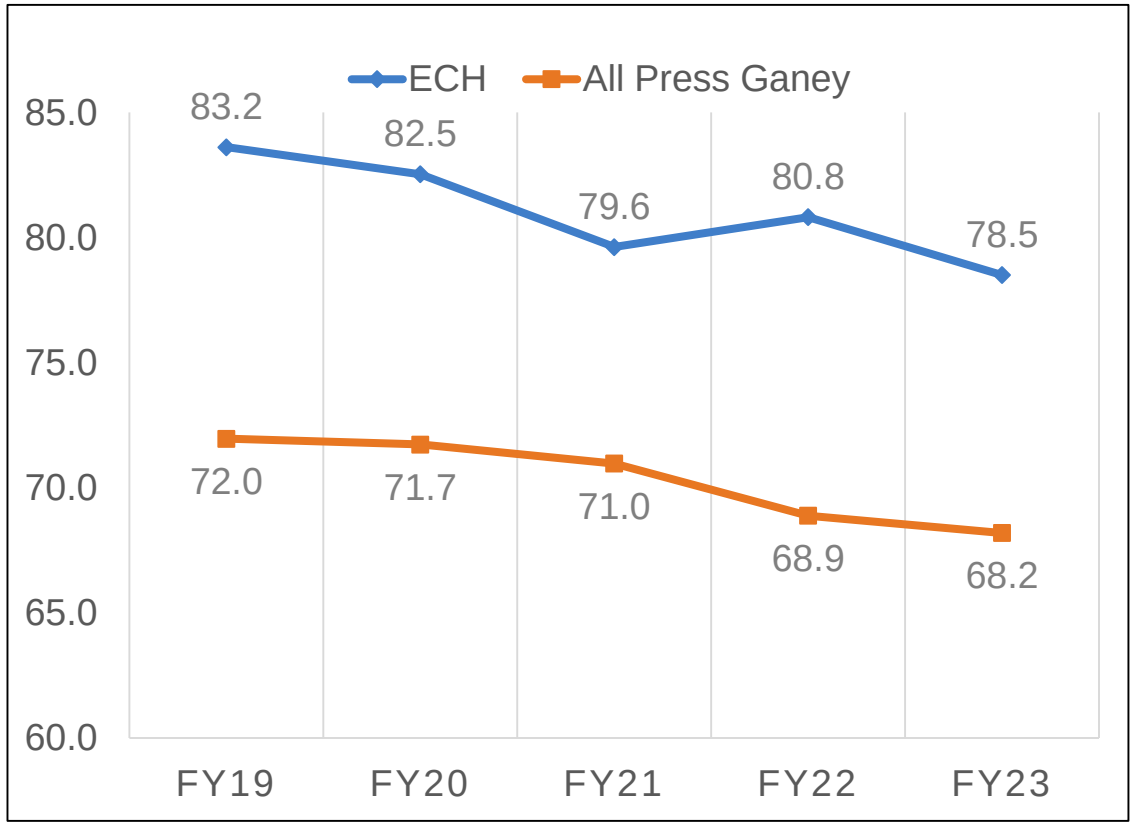
El Camino Health®

Source: NRC Health “Moving the HCAHPS Needle”, June 2023

ECH is consistent with national trends, but continues to outperform peers

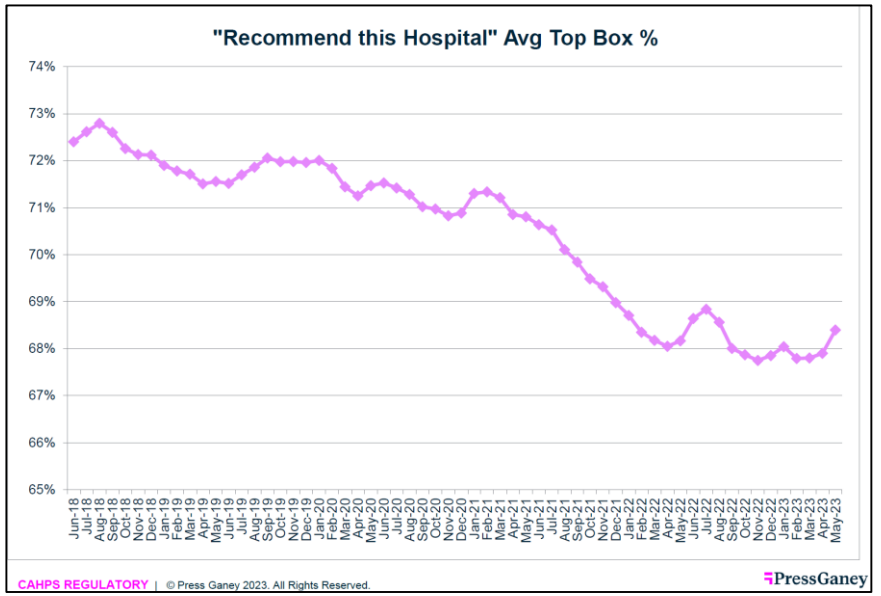
Inpatient Top Box Score- Likely to Recommend
FY19 to FY23

ECH (excluding MBU) vs. All Press Ganey Hospitals



In FY23, ECH's "Likely to Recommend" score performed:

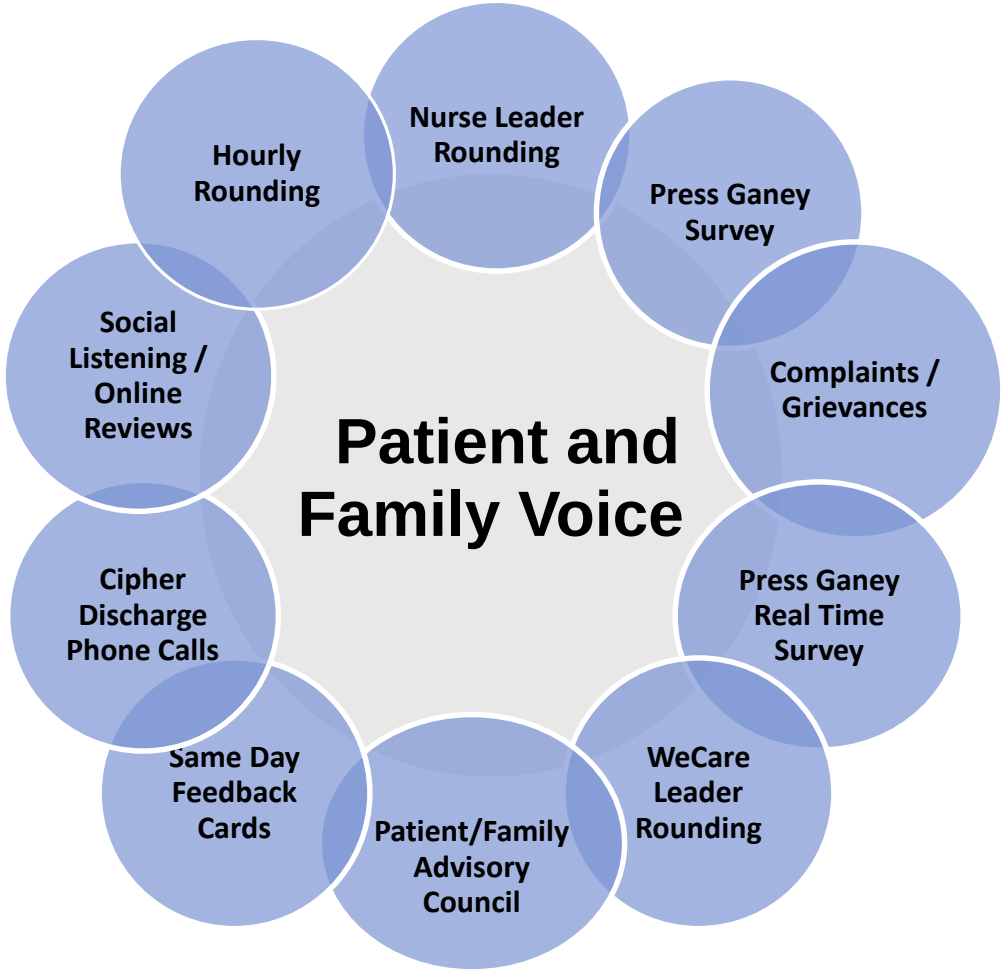
- **80% better** than all US hospitals
- **73% better** than all California hospitals
- **75% better** than all Bay Area hospitals



Source: Press Ganey

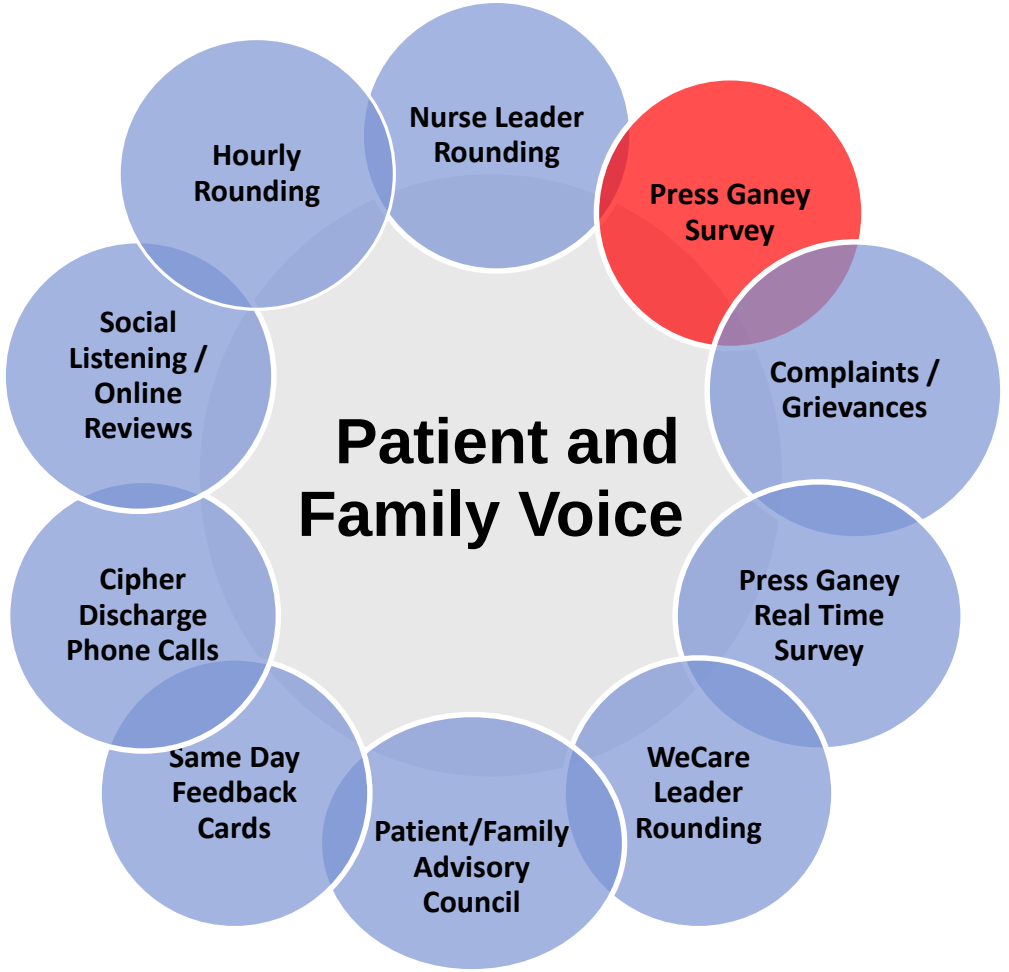
El Camino Health – FY23

Listening to the Power of Patient and Family Voice



The voices of our patients and families can bring to light ***both*** opportunities for **improvement** as well as **successes** to be celebrated.

Listening to the Power of Patient and Family Voice



The voices of our patients and families can bring to light ***both*** opportunities for **improvement** as well as **successes** to be celebrated.

Press Ganey Survey

Our surveys:

- 11 surveys across the enterprise (Inpatient/MCH, NICU, Ambulatory Surgery, Outpatient Services, Emergency Department, Oncology, Clinics, Telehealth/Clinics, Urgent Care, Inpatient Behavioral health)

Our modes and methodology:

- Surveys currently in Spanish and English
- Utilize paper and e-survey (text/email) surveys (only paper mode responses accepted by CMS until January 2025). Extract includes patient discharged two days prior (T-2). Randomized sampling survey sent via paper or e-survey mode. HCAHPS paper sampling selected first (paper sampling rate set to 33%) and all remaining patients qualify for text / email survey (100% unlimited). We survey 100% of our patients*
- We utilize and report on e-survey adjusted scores. Press Ganey offers e-adjustment to received responses to reduce bias

Our returns / responses:

- Total FY23 Inpatient surveys returned: Unadjusted 2,479 Adjusted 2,177 (this is what we report out) CMS adjustment (per Press Ganey) n=899
- Response rates nationally and at ECH have declined over the last decade (varies by service line from 12%-28%)

HCAHPS requirement:

- Per CMS, the HCAHPS sample must be drawn according to random sampling protocol. CMS requires minimum 300 returned paper surveys.
- To ensure that differences in HCAHPS results reflect differences in hospital quality only, HCAHPS survey results are adjusted by CMS for patient-mix and mode of data collection. Only the adjusted results are publicly reported and considered the official results. Several questions on the survey, as well as items drawn from hospital administrative data, are used for the patient-mix adjustment by CMS

Service Area	# returned in FY23 (enterprise)
Inpatient	2,177
Mother / Baby	577
Ambulatory surgery	2,469
Outpatient Services (imaging, rehab, cardiac rehab, lab)	6,106
Oncology	1,731
Emergency Department	4,496
Medical Practice / Clinics	11,312
Telehealth (Clinics)	964
NICU	54
Urgent Care	Started 7/1

*We do not survey deceased, confidential or patients previously admitted within last 90 days

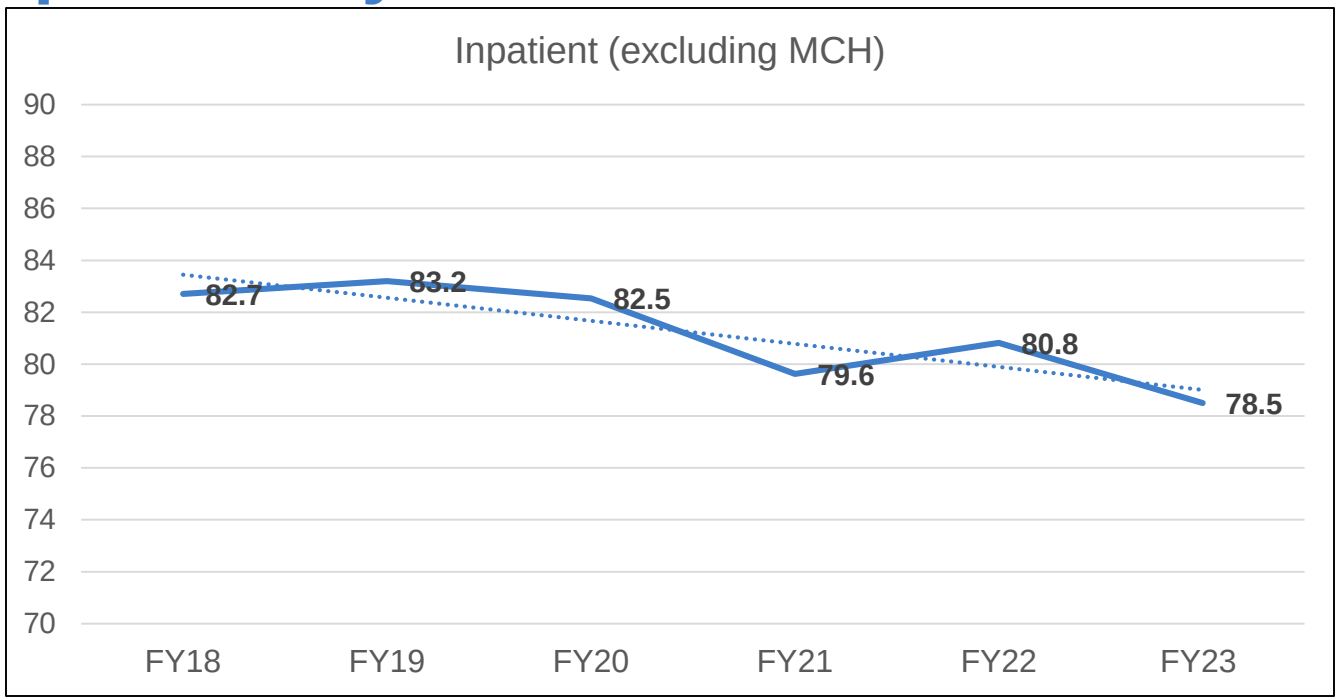
ECH Final FY23

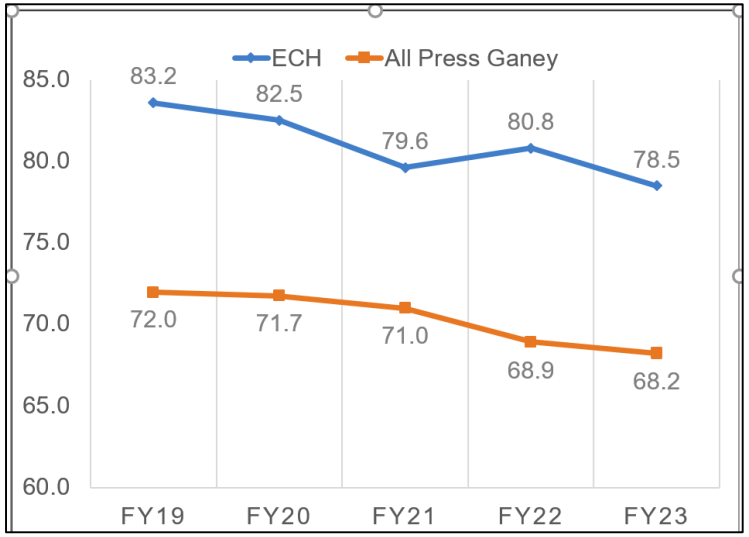
ENTERPRISE	FY22 (Baseline)	FY23 Target Goals	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	FYTD
*IP Units Enterprise	80.8	81.0	82.7	82.3	75.0	80.1	75.5	80.2	74.6	77.4	78.0	73.5	79.4	82.4	78.5
%tile	86		89	89	72	86	74	86	70	80	81	68	83	89	80
n'	2200		185	186	196	176	155	197	189	155	168	189	194	187	2177
MCH Enterprise	81.3	81.5	74.2	72.1	70.5	69.6	71.8	72.1	85.1	83.7	82.2	70.3	75.9	75.0	75.0
%tile	86		67	60	58	55	62	63	93	92	90	58	74	69	75
n'	640		66	68	61	46	39	43	47	43	45	37	54	28	577
ED Enterprise	74.5	75.0	68.4	70.9	72.1	73.9	70.0	73.1	77.2	73.7	71.1	74.7	66.9	69.7	71.7
%tile	74		55	64	69	73	63	72	83	74	66	74	48	55	62
n'	3697		436	395	351	348	377	401	359	353	394	368	371	343	4496
*ECHMN - All	83.2	83.4	78.8	82.1	82.7	82.7	79.5	82.7	83.3	84.1	83.4	83.8	83.7	84.0	82.7
%tile	30		13	25	28	27	16	27	30	34	30	31	30	31	25
n'	853		847	820	734	848	918	963	953	957	1079	1301	930	962	11312
ECHMN - Urgent Care	77.8	80.7	67.7	76.9	76.1	80.4	66.0	79.6	81.1	77.1	83.0	83.0	76.3	75.2	77.2
%tile	11		3	10	9	19	2	16	20	10	28	27	9	8	11
n'	194		99	78	67	92	106	142	132	105	100	153	135	117	1326

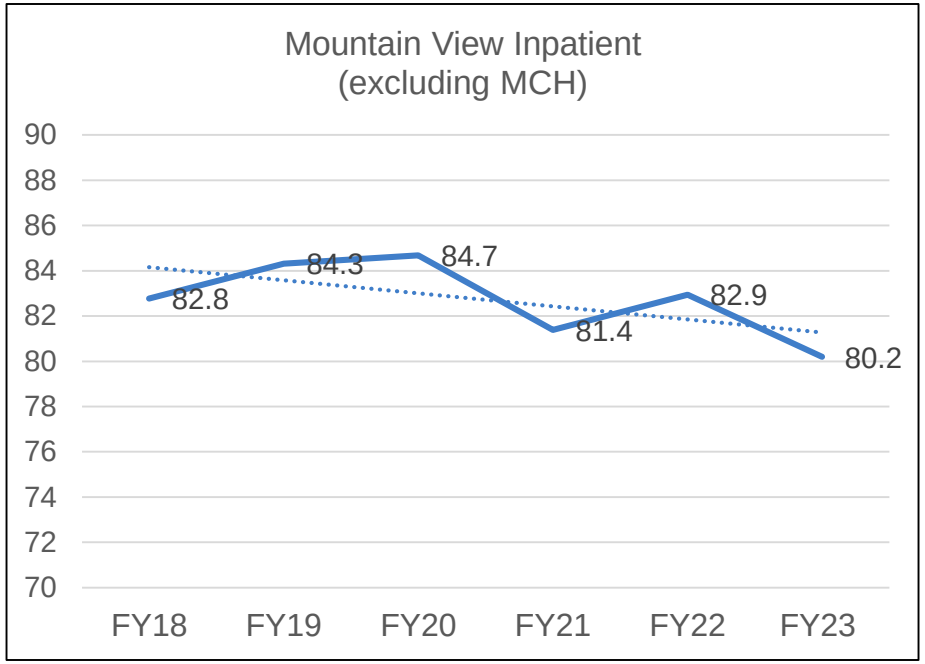
*All PG LTR e survey adjusted * Indicates Incentive Goal*

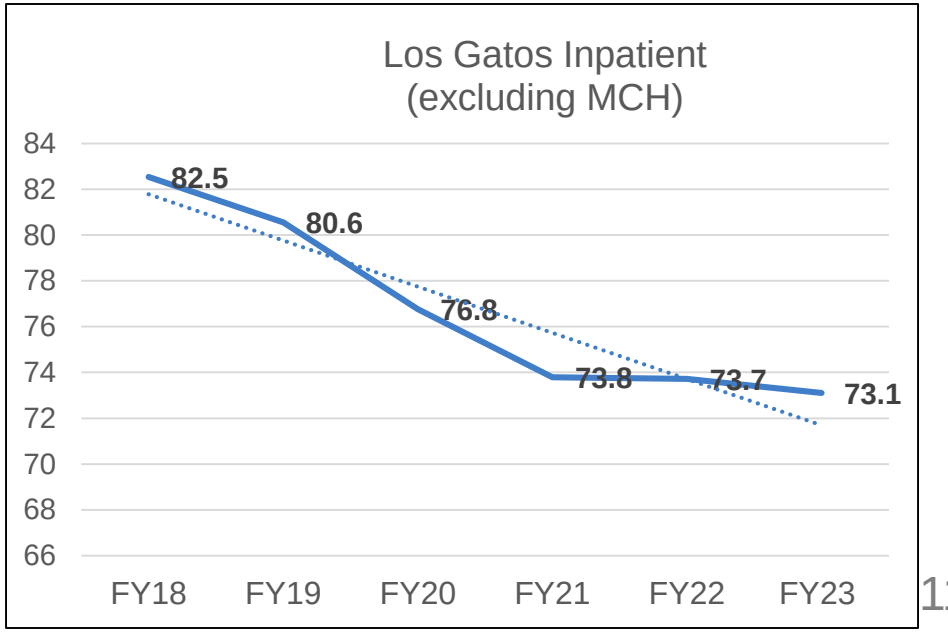
ENTERPRISE	FY22 (Baseline)	FY23 Target Goals	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	FYTD
*IP Units Enterprise	80.8	81.0	82.7	82.3	75.0	80.1	75.5	80.2	74.6	77.4	78.0	73.5	79.4	82.4	78.5
%tile	86		89	89	72	86	74	86	70	80	81	68	83	89	80
n'	2200		185	186	196	176	155	197	189	155	168	189	194	187	2177
IP Units MV	82.9	83.0	82.6	82.9	75.8	83.7	79.2	81.3	76.2	77.0	78.3	76.8	83.3	84.2	80.2
%tile	89		89	90	75	92	83	88	75	79	82	78	91	91	84
n'	1694		138	146	149	129	125	150	143	100	129	138	156	139	1642
IP Units LG	73.7	74.0	83.0	80.0	72.3	70.2	60.0	76.6	69.6	78.2	76.9	64.7	63.2	77.1	73.1
%tile	66		89	84	64	57	24	77	54	82	78	39	32	76	62
n'	506		47	40	47	47	30	47	46	55	39	51	38	48	535

Inpatient 6 year trend









FY23 Final Distribution of Responses

CAHPS Frequency Distribution Response Table

Client ID: '24207'			
Questions	**Value**	**%**	**n**
*Recommend the hospital	Definitely no	1.28	21
*Recommend the hospital	Probably no	2.38	39
*Recommend the hospital	Probably yes	16.14	265
*Recommend the hospital	Definitely yes	80.21	1317
*Recommend the hospital	Total		1642

96.4%
Mountain View

Client ID: '6641'			
Questions	**Value**	**%**	**n**
*Recommend the hospital	Definitely no	2.80	15
*Recommend the hospital	Probably no	3.55	19
*Recommend the hospital	Probably yes	20.56	110
*Recommend the hospital	Definitely yes	73.08	391
*Recommend the hospital	Total		535

93.6%
Los Gatos

Client ID: Total			
Questions	**Value**	**%**	**n**
*Recommend the hospital	Definitely no	1.65	36
*Recommend the hospital	Probably no	2.66	58
*Recommend the hospital	Probably yes	17.23	375
*Recommend the hospital	Definitely yes	78.46	1708
*Recommend the hospital	Total		2177

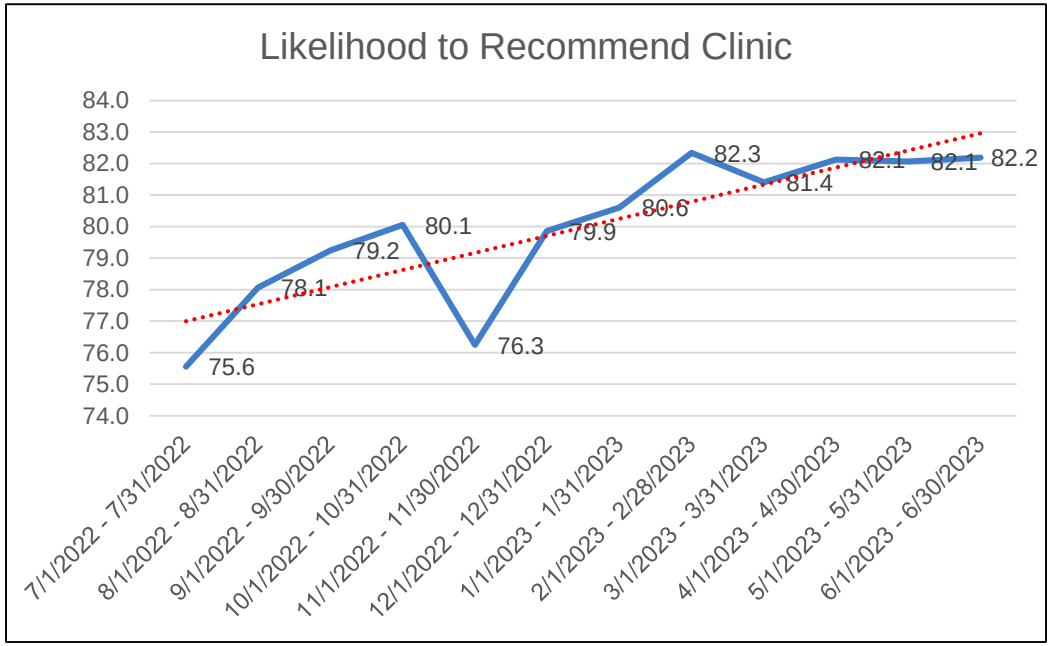
95.7%
Enterprise

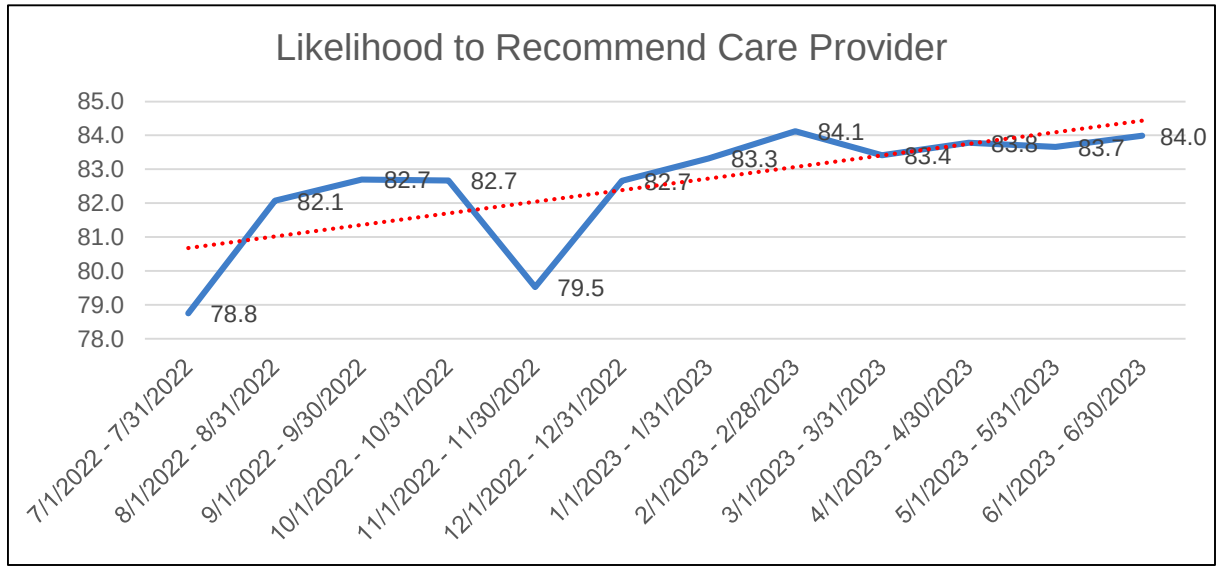
ECHMN Final FY23

ENTERPRISE		FY23 Target Goals	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	FYTD
*ECHMN - All	LTR CP Top Box Score	83.4	78.8	82.1	82.7	82.7	79.5	82.7	83.3	84.1	83.4	83.8	83.7	84.0	82.7
	National Facilities %tile Rank		13	25	28	27	16	27	30	34	30	31	30	31	25
	Sample size (n)		847	820	734	848	918	963	953	957	1079	1301	930	962	11312

Specialty Area	FY23	
	% Top Box	% Very Good/ Good
ECHMN - All	80.2	94.7
Primary Care	79.5	94.4
Specialty Care	82.2	96.0
Urgent Care	76.1	91.4

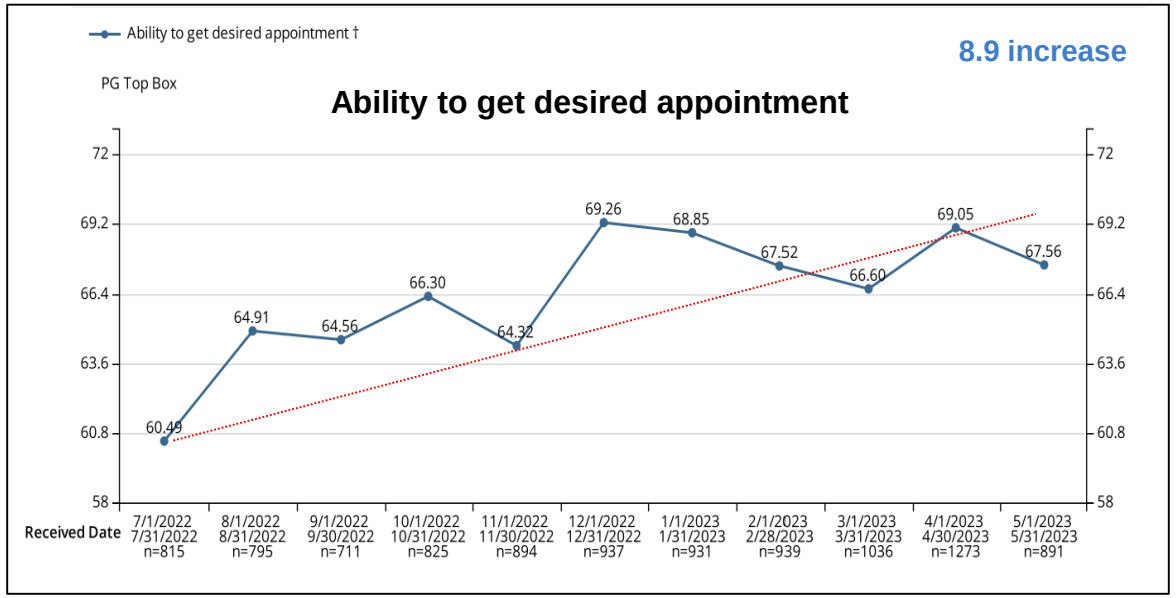
+6.6 points

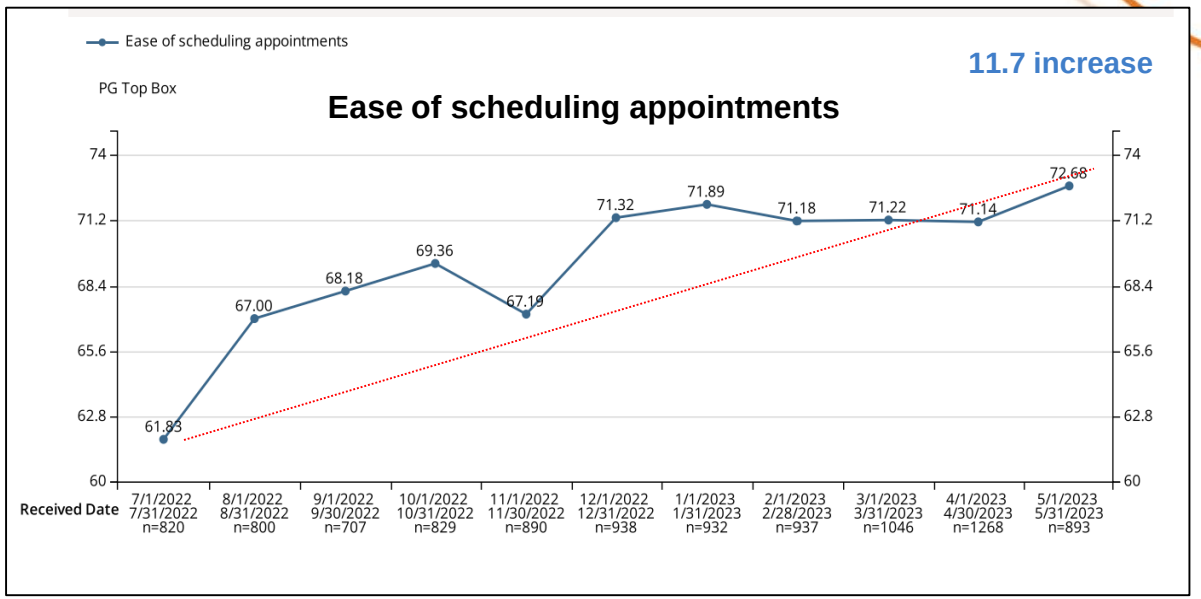


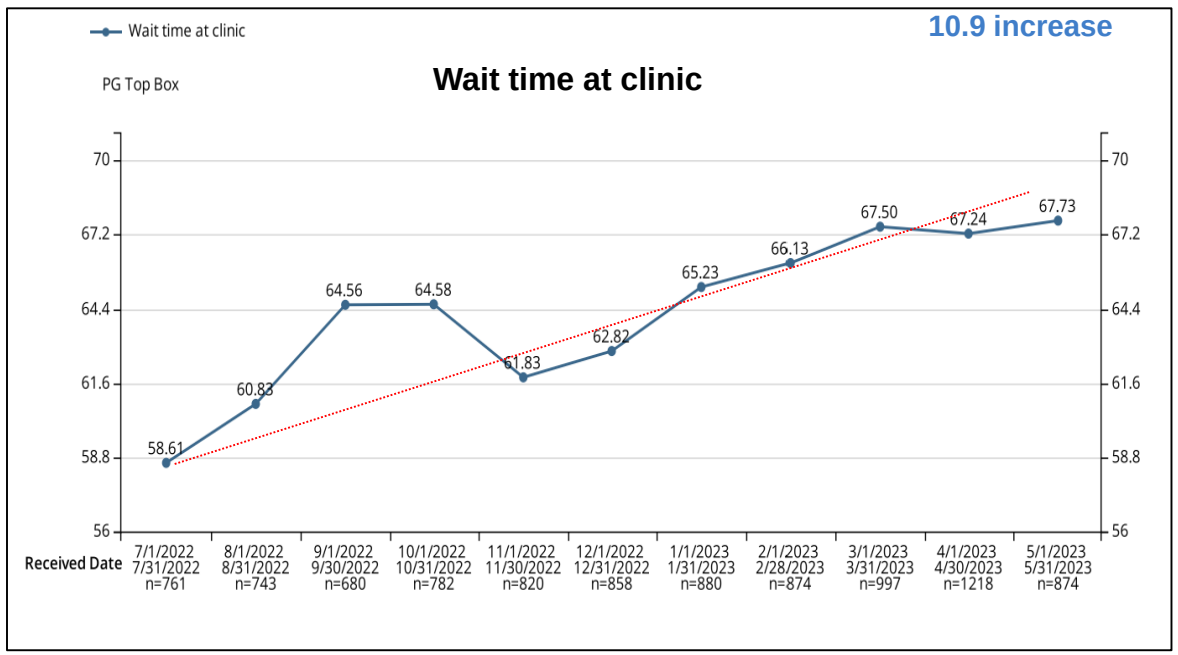


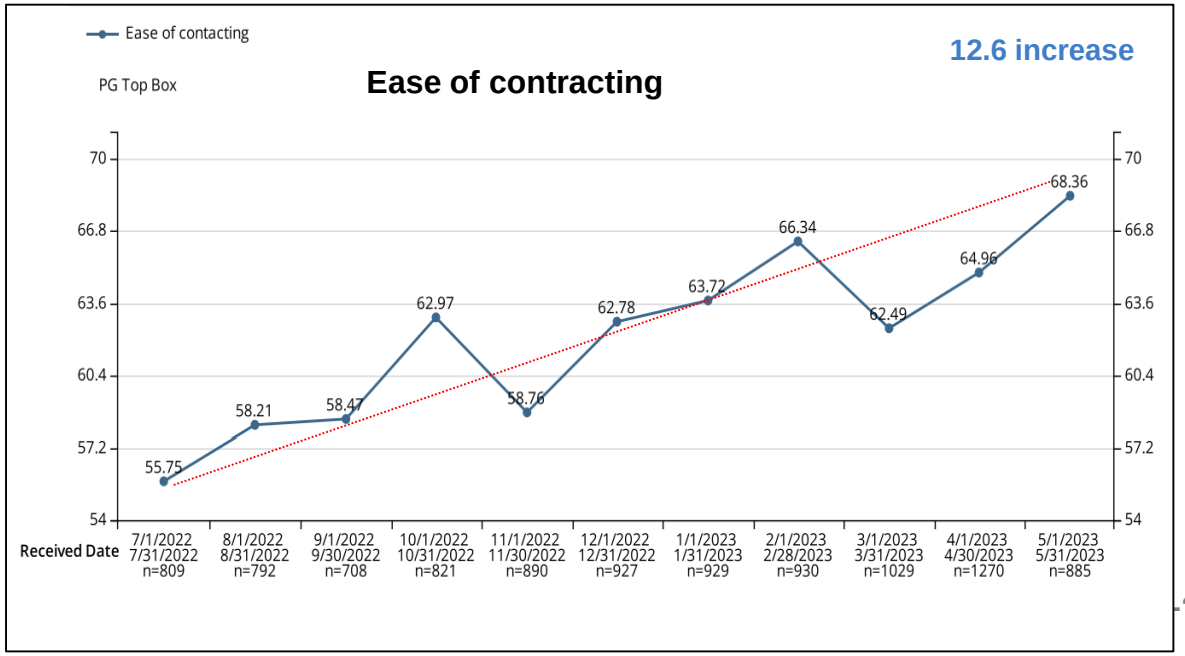
+5.2 points

Frictionless Questions

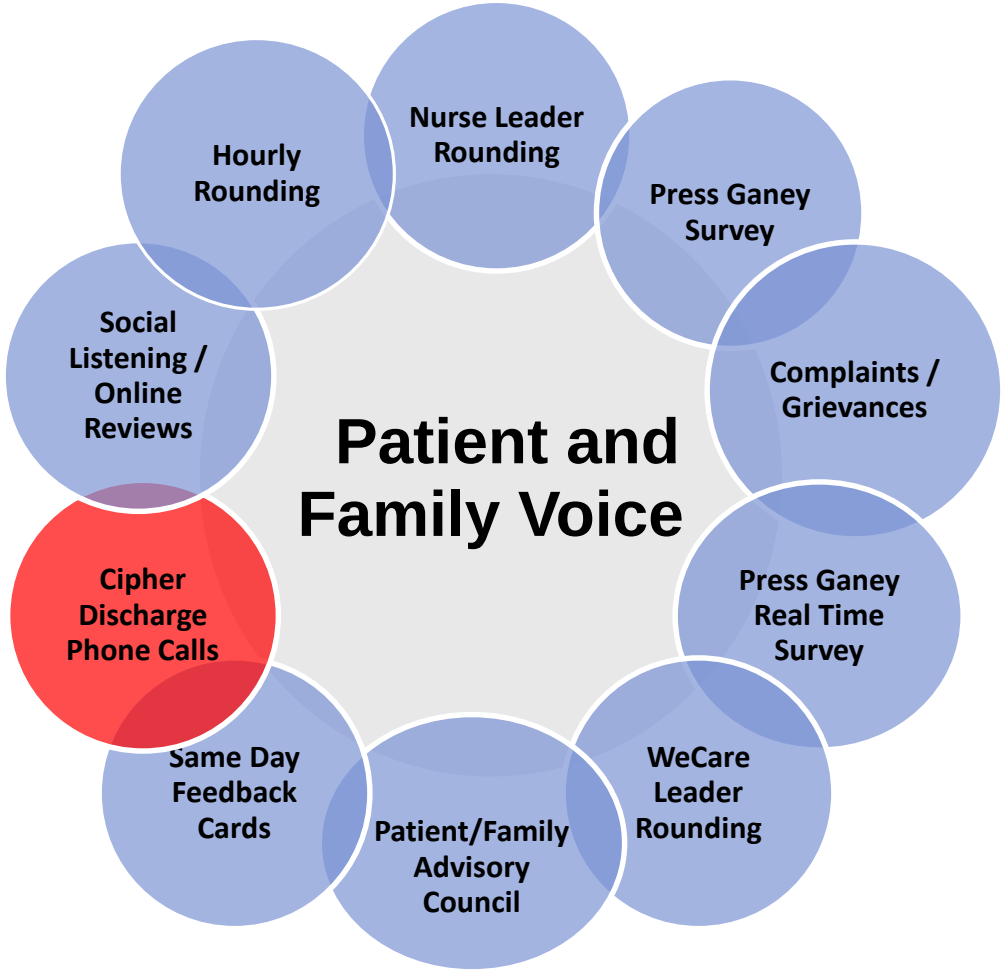








Listening to the Power of Patient and Family Voice

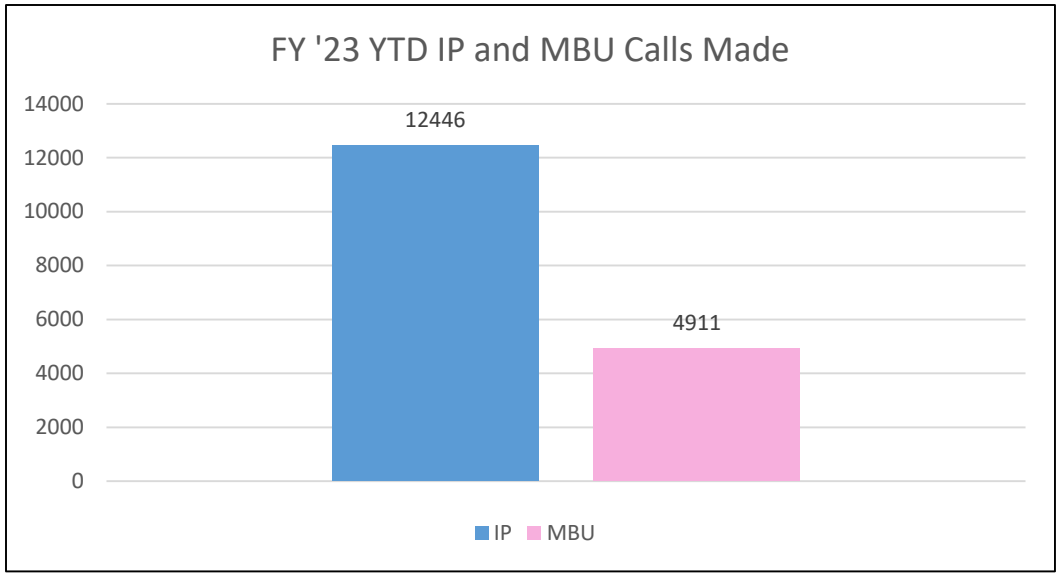


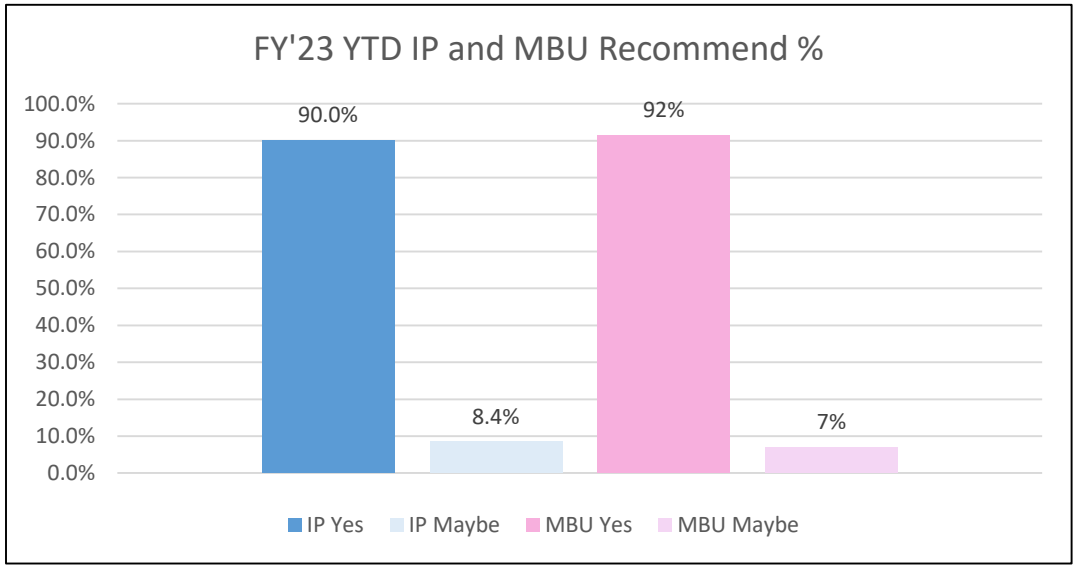
The voices of our patients and families can bring to light ***both*** opportunities for **improvement** as well as **successes** to be celebrated.

Post Discharge Phone Calls

- 100% of inpatients (*including* MCH) discharged home gets a call
- Calls are made 48 hours post discharge M-Sat 8am, 2pm, 9am (next day)
- Calls are made using a local area code (650)
- Caller ID displays our branding
  - Landline it will say “El Camino Health’
  - Mobile Device “Mountain View, CA”
- Dan Woods voice introduces the call and professional talent continues
- We reach patients by phone or SMS – we allow patients to call inbound and complete the call
- Call available in English, Spanish and Mandarin

Post Discharge Phone Calls Data FY23

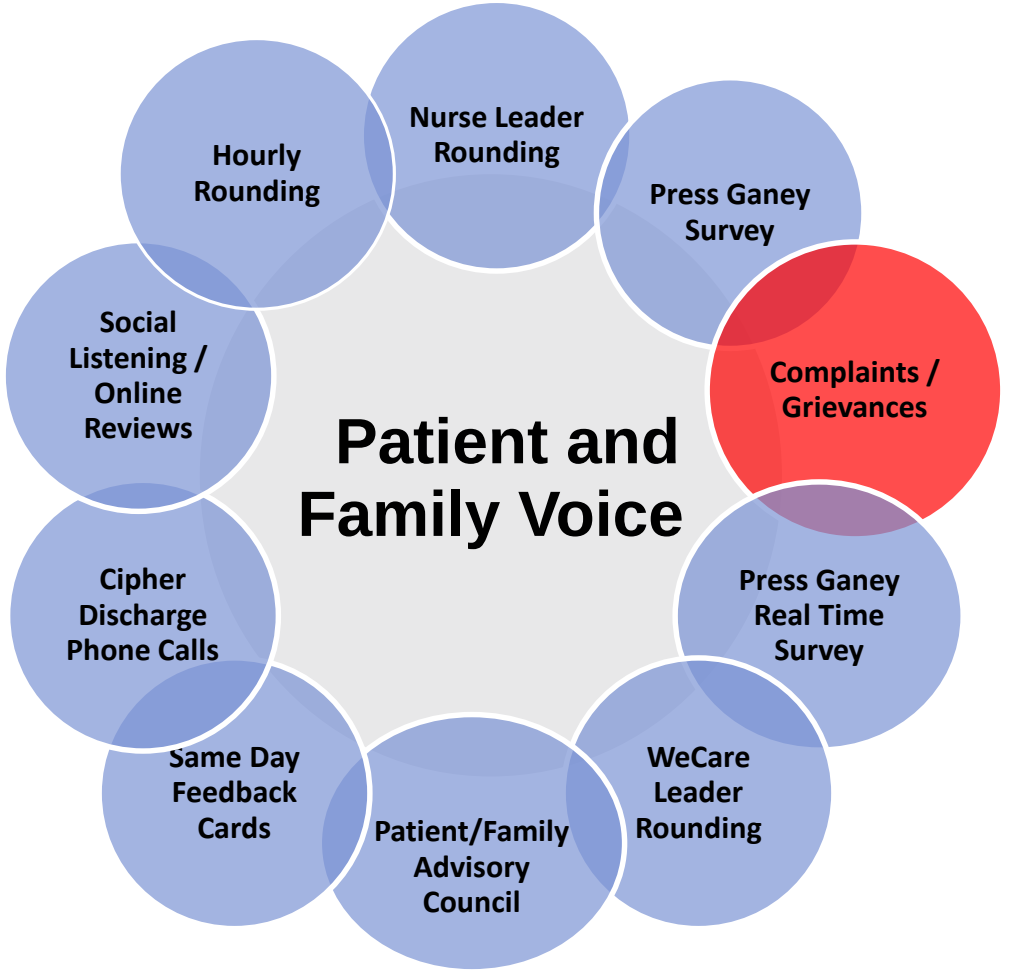




- 17,357 calls made
  71% patients answered & responded
- Questions asked:
  - Follow up medication (did you get and understand your medication?), discharge experience, refer others, follow up appointment, open ended comments
- Higher scores for clinically reached patients:
  - Communication with doctors 5.9% higher
  - Communication with Nurses 4.2% higher
  - LTR 4.2% higher
- Patients discharged and experienced an issue gave significantly lower scores than those who discharged without issue. However, LTR increases 13% when reached for follow up after reporting an issue
- Target is to reach 100% of those that have an issue

FY23	# of e-survey adjusted PG Surveys returned	# of DC calls completed
Inpatient	2,177	12,446
MCH	577	4,911

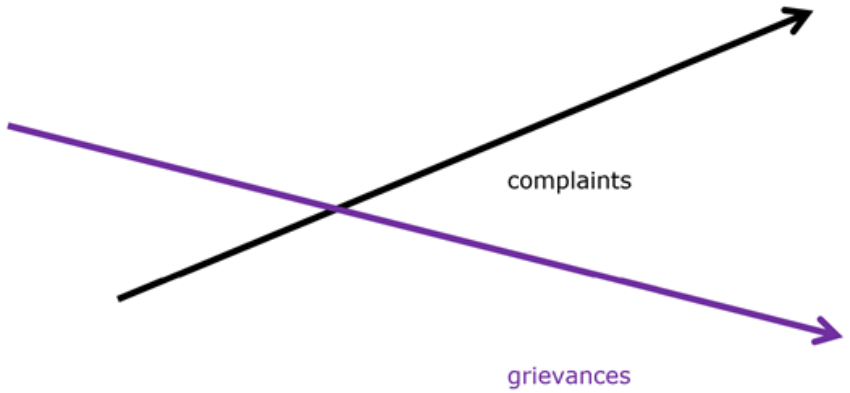
Listening to the Power of Patient and Family Voice



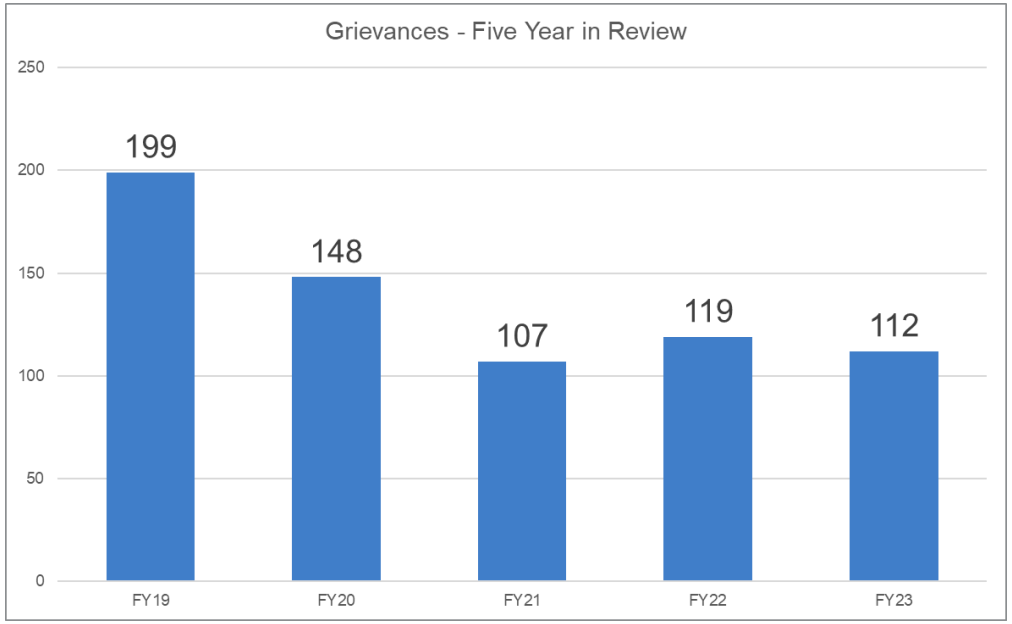
The voices of our patients and families can bring to light ***both*** opportunities for **improvement** as well as **successes** to be celebrated.

Patient Feedback: Complaints and Grievances

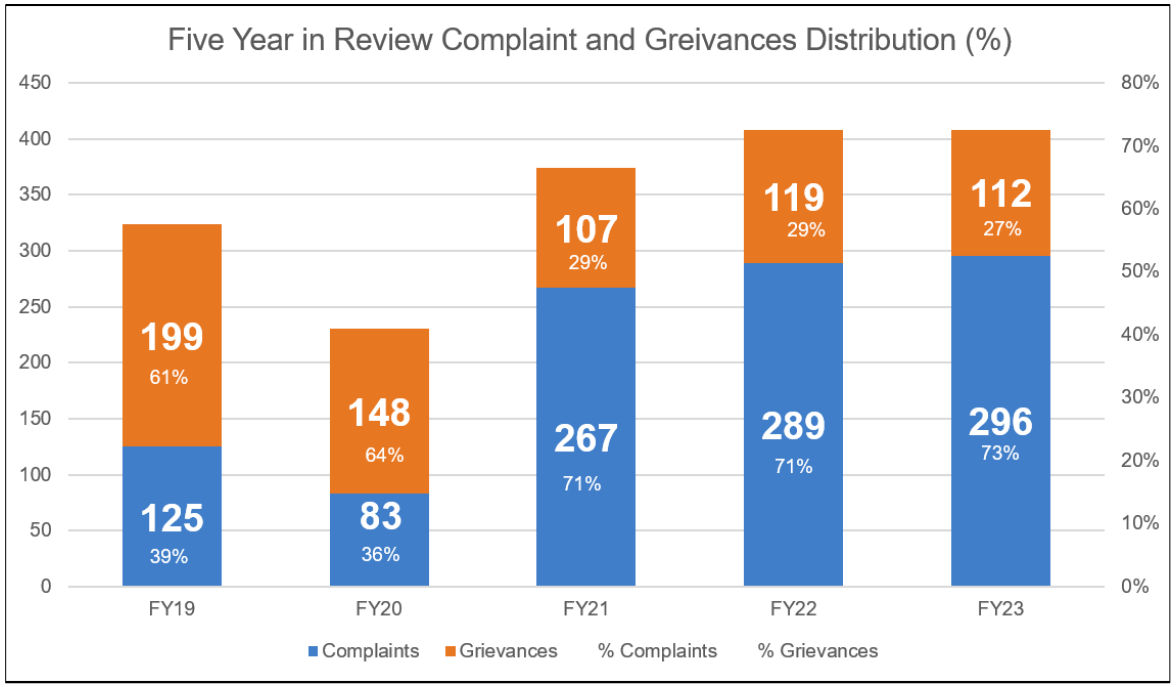
Complaint	Grievance
A complaint is a concern voiced by a patient or the patient's representative, about service, care, or treatment that can be resolved quickly by the staff present. A complaint is considered resolved when the patient is satisfied with the actions taken on his or her behalf. Examples: billing, lost and found, professionalism, follow up can be done in person	A Grievance is a written or verbal complaint by a patient, or patient's representative, about the patient's care. When a verbal complaint by the patient is not resolved at the time of the complaint by staff present, it automatically becomes a grievance. Typically more serious in nature and requires and investigation regarding quality of care, concerns submitted in writing, regulatory requirement required for follow up



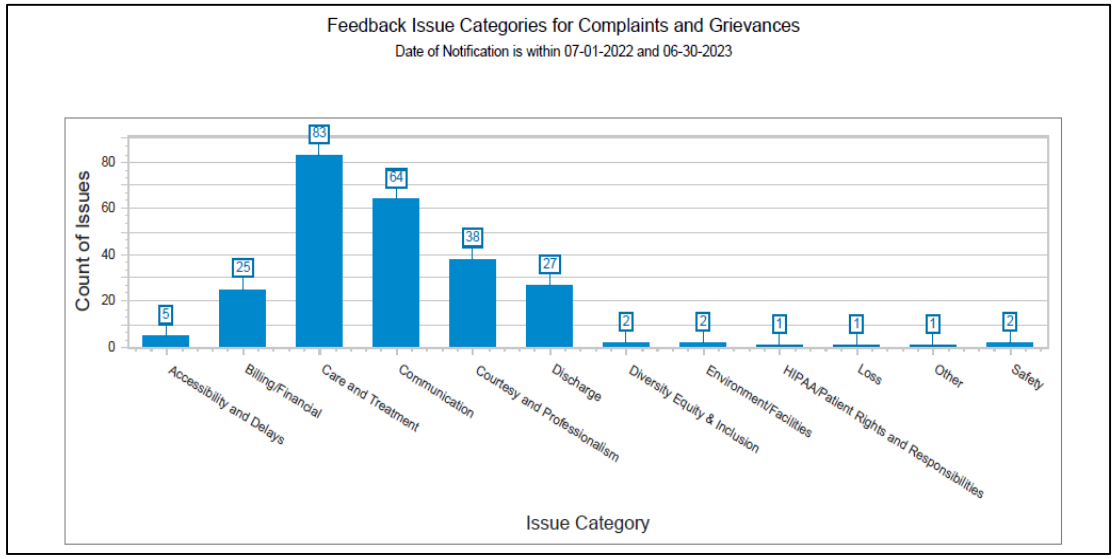
Complaints and Grievances: Five (5) Year in Review

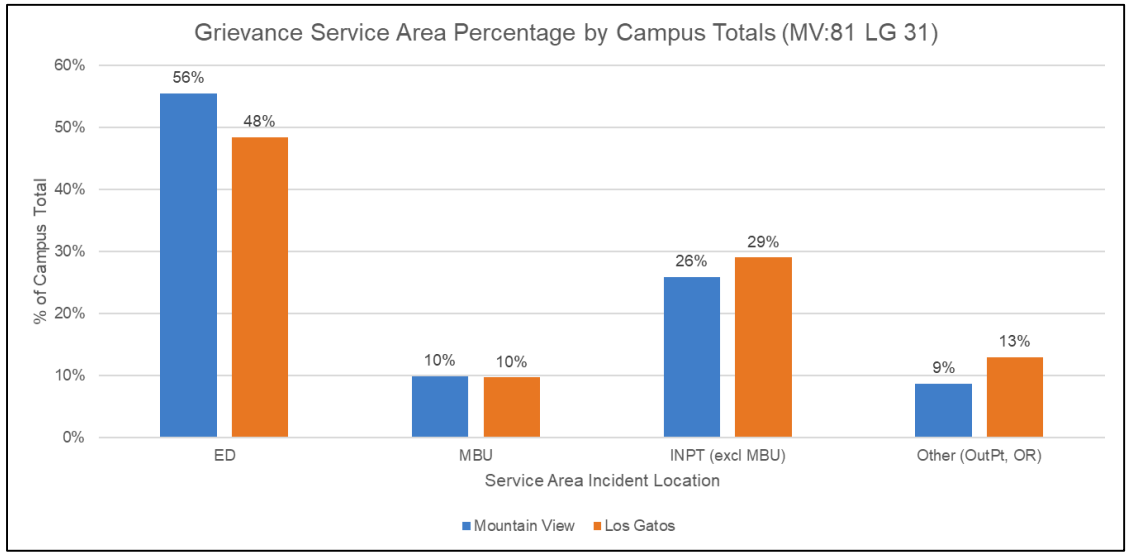


Rounding, proactive service recovery, and addressing concerns in the moment and / or while patient is still in house, helps prevent complaints from turning into grievances



FY23 Grievance/ Complaints by Category/Location/Census





Fiscal year	# ED Visits	# ED Grievances	% per D/C
FY23	76,990	60	0.08%
FY22	68,682	63	0.09%
FY21	52,059	41	0.08%
FY20	56,334	71	0.13%
FY19	62,355	100	0.16%

Fiscal Year	Total Discharges	# Inpatient Grievances	% Per D/C
FY23	67,046	41	0.06%
FY22	65,606	49	0.07%
FY21	58,616	55	0.09%
FY20	54,386	77	0.14%
FY19	54,114	99	0.18%

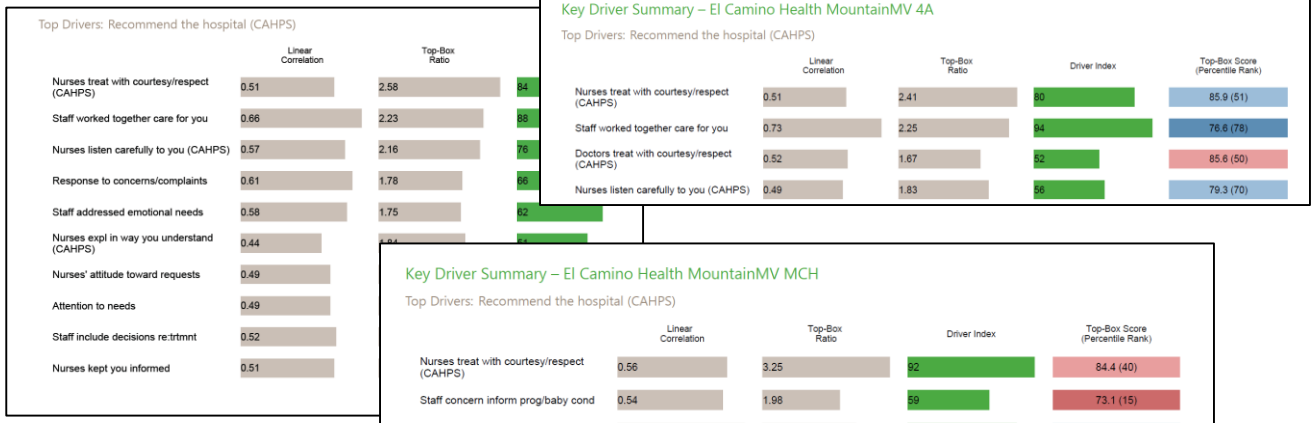
El Camino Health – FY24

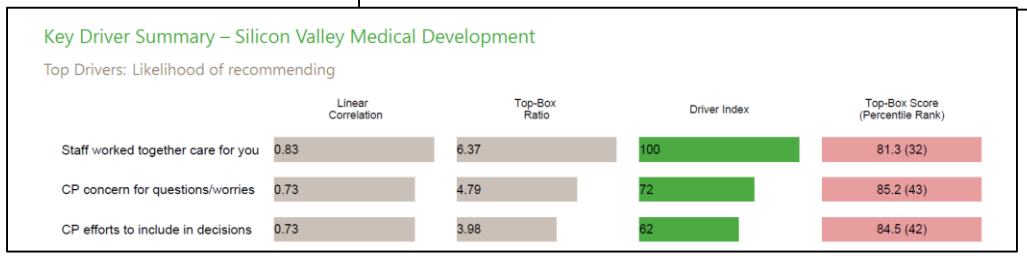
Turn 4’s to 5’s
Probably to Definitely

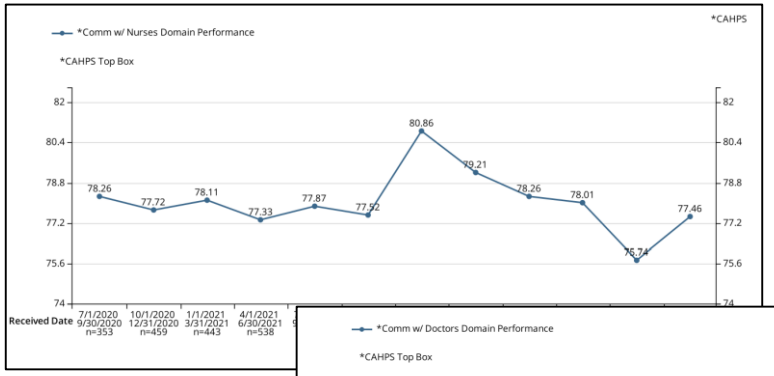
FY24 Targets and YTD Progress

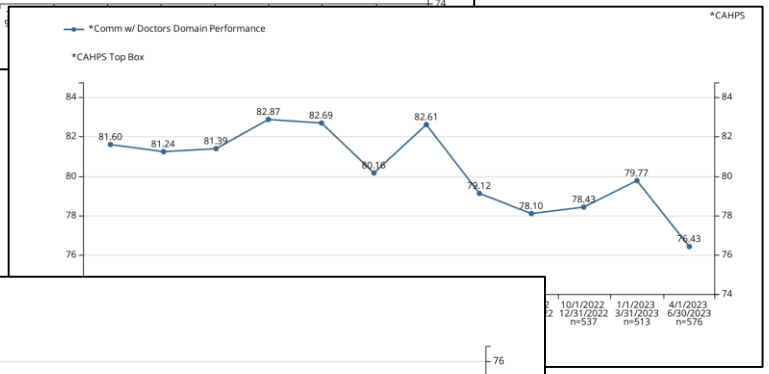
FY24 Incentive/Qualty	FY23 (Baseline)	FY24 Target Goals	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	FYTD
***IP Units Enterprise**	**78.5**	**76.4**	**79.2**												**79.2**
%tile	80		80												80
n'	2177		183												183
MCH Enterprise	**75.0**	**75.0**	**84.1**												**84.1**
%tile	70		91												91
n'	577		44												44
ED Enterprise	**71.7**	**71.7**	**76.9**												**76.9**
%tile	62		76												76
n'	4496		412												412
***ECHMN - All**	**80.7**	**81.3**	**82.2**												**82.2**
%tile	27		34												34
n'	10017		1286												1286

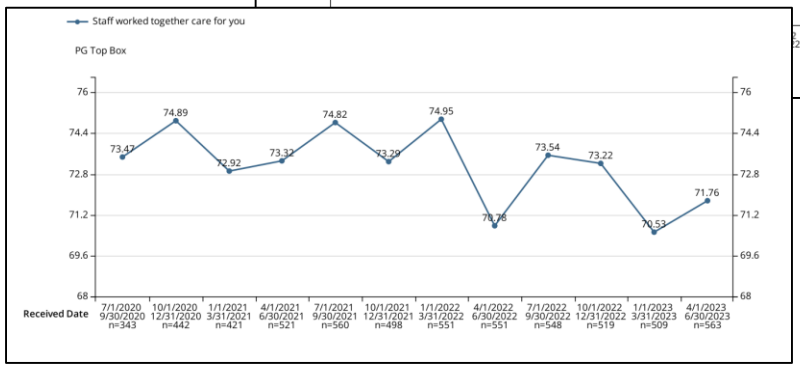
Key Drivers





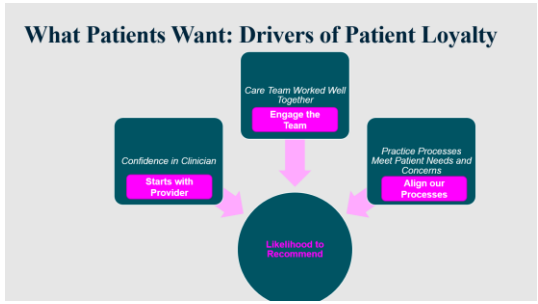


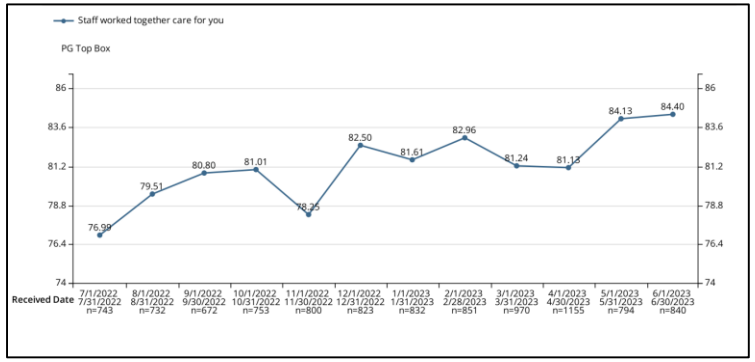




Key Drivers: A key driver analysis **examines the relationships between potential drivers and behavior such as the likelihood** of a recommendation

- Nurse Communication
- Physician Communication
- Staff Worked Together (Teamwork)





FY24 Plan – best practices that we will continue and new efforts to achieve our target

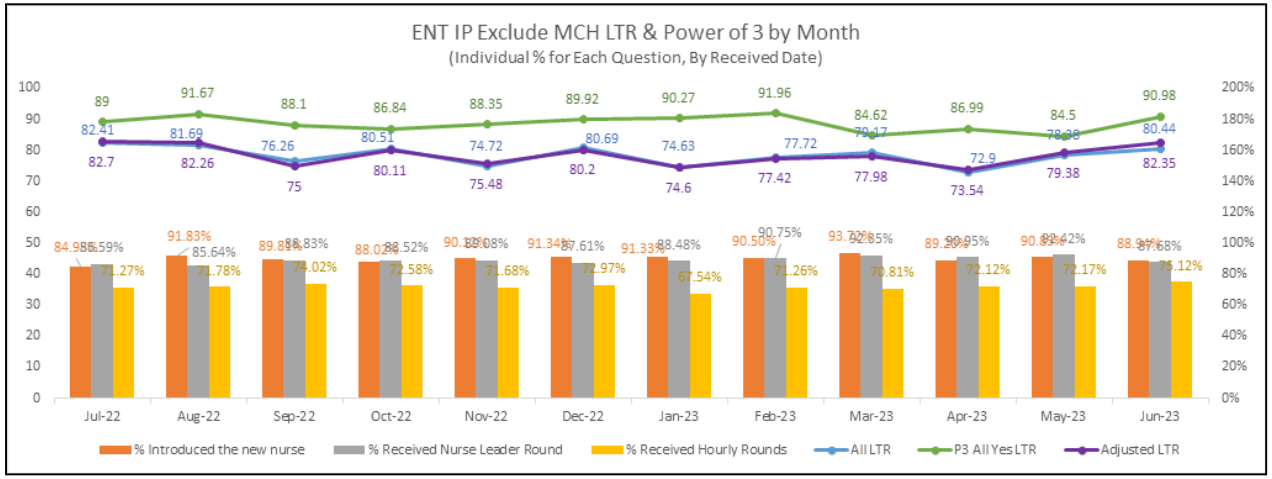
- Power of 3 (nurse leader rounding, hourly rounding, bedside shift report)
- WeCare Leader Rounding
- WeCare Behavior Standards (including service recovery and refresher trainings)
- Staff worked together (teamwork best practices)
- Nurse Communication Coaching (onboarding, huddles, UPC meetings)
- Each unit and each clinic key driver analysis and plan development
- Increase recognition with paper wow cards
- Real time feedback – Forsta QR and text/email surveys (inpatient & outpatient)
- Patient Experience Literature Portal – library of resources accessible to all
- Physician with Nurse Rounds Pilot – 4B
- Language Pilot – 3C
- MD Communication Focus (MD Coaching / Shadowing, Practicing Excellence)
- Hourly Rounding (PE, Safety, Quality, HRO)

FY24 Plan – best practices that we will **continue** and new efforts to achieve our target

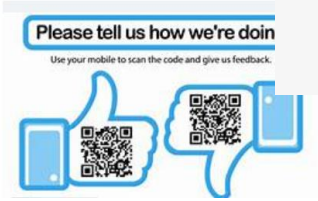
- WeCare Patient Amenities Cart
- GetWell TV instant notification to unit leader on patient experience questions
- Discharge lounge utilization
- Additional language to current surveys (Chinese to be added)
- New/ Refresh GWN Welcome Video
- Schwartz Rounds
- Expand and customize Cipher Discharge Phone Calls

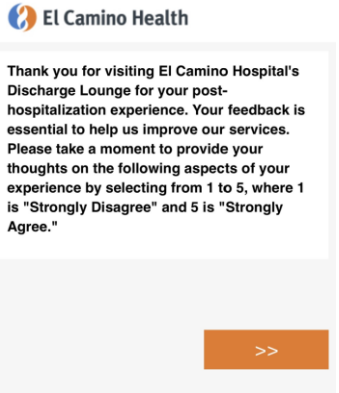
Examples

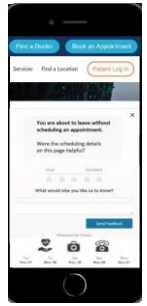
Power of 3



Real Time Feedback







Available with text, email, QR code, scale, open ended, yes/no, smiley face

MD/RN Rounding Pilot

Questions

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, and Chief Quality Officer
Date: September 5, 2023
Subject: Proposed FY24 Measures to include on STEEEP Dashboard

Background:

The ECH STEEEP Quarterly Dashboard was introduced to the Board Quality Committee on August 3, 2020. This governance level report was created in response to a "request for a simplified quality and safety dashboard that the Board can use as a tool to monitor quality and safety performance without repeating the oversight work of the Quality Committee". (Mark Adams, 2020) The quality committee members endorsed the recommendations of the Institute for Healthcare Improvement (IHI) in their 2019 white paper "Framework for Effective Board Governance of Health System Quality" to use the STEEEP framework as a "clear and consistent framework to guide core quality knowledge, expectations, and activities to better govern quality." (Institute for Healthcare Improvement, 2019)

Shortly after the conclusion of the fiscal year, the Quality and Executive Teams (CMO, CNO, and CQO) assess areas of sustained excellent performance and those areas requiring focused improvement. Some of the sources of this information are;

1. Enterprise Quality Experience and Safety Dashboard (monthly)
2. STEEEP Dashboard (quarterly)
3. Quality Council individual department level quality and safety process improvement initiatives

Recommendation:

Based on the methodology and findings identified above we recommend the following updates to the FY24 STEEEP Dashboard are displayed on the attached document, FY24 STEEEP Dashboard Measure Proposal.

The Quality Committee will review the first FY24 STEEEP dashboard in November 2023 prior to sharing the report with the ECHB during their November 2023 meeting.

Attachment:

1. FY24 STEEEP Dashboard Measure Proposal

Bibliography

Institute for Healthcare Improvement. (2019, January 9). *What Boards Must Do to Achieve Better Quality Health Care.* Retrieved from Institute for Healthcare Improvement: https://www.ihi.org/communities/blogs/what-boards-must-do-to-achieve-better-quality-health-care

Mark Adams, M. C. (2020, August 3). El Camino Hospital Board of Directors, Quality Committee of the Board Meeting Memo . Mountain View , California.

	STEEEP FY23
Safe Care	HAC Index 1.0
	HAC Component: Cdiff
	~~HAC Component: Hosp Acquired Pressure Injury (HAPI)~~
	HAC Component: Surgical Site Infection (SSI)
	HAC Component: nvHAP
	~~HAC Component: Patient Falls on IP Units~~
Timely	~~Stroke TTITT~~
	~~Stroke Door to groin~~
	Imaging TAT
Effective	Readmission
	Mortality
	Sepsis mortality
	NTSV Cesarean Section Rate
Effici-ent	ED Throughput time to Discharge
Equitable	~~% Patients - Ethnicity documented~~
	~~% Patients - Race documented~~
Patient Centered	Inpatient HCAHPS
	MCH HCAHPS
	ED LTR
	ECHMN LTR

	STEEEP FY24 (* = new measure for FY24 STEEEP)
Safe Care	HAC Index 2.0*
	HAC Component: Cdiff
	HAC Component: CAUTI*
	HAC Component: CLABSI*
	HAC Component: nvHAP
	Surgical Site Infections (not in HAC, continue to track)
Timely	Lab STAT Troponin TAT for ER (received to verification)
	Imaging TAT
Effective	Readmission Index
	Mortality Index
	Sepsis mortality Index
	NTSV Cesarean Section Rate
Effici-ent	Length of Stay*
	ED Throughput time to Discharge
Equitable	Homeless Discharge Documentation Compliance*
	Quality Council HE item included in PI efforts (% of depts)*
	Sepsis Bundle Compliance by Race*
	Preferred language concordance, patient reg and nurse intake*
Patient Centered	Inpatient HCAHPS
	MCH HCAHPS
	ED LTR

El Camino Health

Clinical Labs & Pathology - FY 2023 YTD Performance

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	FYTD 2023 Performance	Baseline FY 2022	Target for FY 2023	Trend Graph
MOUNTAIN VIEW LABORATORY PERFORMANCE METRICS					
DEPARTMENT - CHEMISTRY					
STAT Troponin TAT (EMERG) - Received to Verification < 40 minutes *Latest Data Month: MARCH 2023*	73.0%	85.0%	86.9%	90% completion in < 40 min