El Camino Health

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

Monday, February 5, 2024 – 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: 980 9115 1479#. 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	ACTION	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	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** a. Oral Comments *This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. Written Public Comments *Comments may be submitted by mail to the El Camino Hospital Board Quality Committee at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	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.*	Carol Somersille, MD Quality Committee Chair	Motion Required	**5:37 – 5:47**
	a. Approve Minutes of the Open Session of the Quality Committee Meeting (12/04/2023) b. Approve Minutes of the Closed Session of the Quality Committee Meeting (12/04/2023) c. Receive FY24 Pacing Plan d. Receive Committee Follow-up Item: 6/1/2020 Report on Obstetrical Lacerations e. Receive Committee Follow-Up Item: Hand Hygiene Project Overview			
6.	**VERBAL CHAIR'S REPORT AND IHI HIGHLIGHTS**	Carol Somersille, MD Quality Committee Chair	Information	**5:47 – 5:52**

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	ACTION	ESTIMATED TIMES
7.	**PATIENT STORY REPORT**	Holly Beeman, MD, MBA, Chief Quality Officer	Information	**5:52 – 5:57**
8.	**RECEIVE Q2 FY24 STEEEP DASHBOARD REVIEW/FY24 ENTERPRISE QUALITY DASHBOARD**	Holly Beeman, MD, MBA, Chief Quality Officer	Motion Required	**5:57 – 6:27**
9.	**RECEIVE EL CAMINO HEALTH MEDICAL NETWORK REPORT**	Shahab Dadjou, President, El Camino Health Medical Network Ute Burness, VP of Quality and Payer Relations	Motion Required	**6:27 – 6:57**
10.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**6:57 – 6:58**
11.	*Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff quality assurance committee* **QUALITY COUNCIL MINUTES** a. Receive Quality Council Minutes (12/06/2023) b. Receive Quality Council Minutes (1/03/2024)	Carol Somersille, MD Quality Committee Chair	Discussion	**6:58 – 7:03**
12.	*Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff quality assurance committee* **Q2 FY24 QUARTERLY QUALITY AND SAFETY REVIEW OF REPORTABLE EVENTS**	Holly Beeman, MD, MBA, Chief Quality Officer	Discussion	**7:03 – 7:08**
13.	*Health and Safety Code Section 32155 and Gov't Code Section 54957 – Deliberations concerning reports on Medical Staff quality assurance committee and report regarding personnel performance of the Medical Staff* **APPROVE CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer	Motion Required	**7:08 – 7:18**
14.	*Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff quality assurance committee* **VERBAL SERIOUS SAFETY/RED ALERT EVENT REPORT**	Holly Beeman, MD, MBA, Chief Quality Officer	Discussion	**7:18 – 7:23**
15.	**RECONVENE OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:23 – 7:24**
16.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:24 – 7:25**
17.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Information	**7:25 – 7:29**
18.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:29 – 7:30 pm**

Next Meeting: March 4, 2024, May 6, 2024, June 3, 2024

El Camino Health

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Health Board of Directors
Monday, December 4, 2023
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Carol Somersille, MD
Melora Simon *(at 5:33 p.m.)*
John Zoglin *(at 5:34 p.m.)*
Pancho Chang
Jack Po, MD (*at 5:35 p.m.)*
Philip Ho, MD *(at 5:37 p.m.)*
Prithvi Legha, MD

Members Absent
Krutica Sharma, MD

Others Present
Holly Beeman, MD, MBA, CQO
Dan Woods, CEO
Mark Adams, MD, CMO
Theresa Fuentes, CLO
Christine Cunningham, Chief Experience and Performance Improvement Officer
Cheryl Reinking, DPN, RN, CNO
Shreyas Mallur, MD, ACMO
Lyn Garrett, Senior Director, Quality
Tracy Fowler, Director, Governance Services
Nicole Hartley, Executive Assistant II
Gabriel Fernandez, Coordinator, Governance Services

**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 Health (the "Committee") was called to order at **5:32 p.m.** by Chair Carol Somersille. A verbal roll call was taken. Committee members Jack Po, Krutica Sharma, Phillip Ho, Melora Simon, and John Zoglin were absent from the roll call. All other members were present at the roll call and participated in person. A quorum was not present until Melora Simon arrived at **5:33 p.m.** John Zoglin arrived at **5:34 p.m.** Jack Po arrived at **5:35 p.m**. Phillip Ho arrived at **5:37 p.m**. No votes were taken on any items until after Committee Member Simon's arrival.	Call to order at **5:32 p.m.**
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	No members of the Committee participated remotely, and no AB 2449 requests were submitted.	
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	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. **Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (11/06/2023), (b) Minutes of the Closed Session of the Quality Committee Meeting (11/06/2023) Received: (c) Progress against FY24 Committee Goals **Movant**: Zoglin **Second**: Po **Ayes**: Somersille, Chang, Simon, Zoglin, Po, Legha, Ho **Noes**: None **Abstain**: None **Absent**: Sharma **Recused**: None	***Consent Calendar Approved***
6. VERBAL CHAIR'S REPORT	Chair Somersille provided a verbal Chair's report to the committee. In the report, Chair Somersille shared the knowledge she gained at the Health Quality Improvement Conference, noting that a key takeaway was how advanced ECH is compared to presenters at the conference on Quality and Health Equity performance and initiatives.	
7. RECEIVE FY24 ENTERPRISE QUALITY DASHBOARD	Dr. Holly Beeman, CQO, presented an update on the FY24 Enterprise Quality Dashboard. Dr. Beeman provided an in-depth analysis of performance, process improvement initiatives, and HAC Index 2.0 performance measures. Discussion about hand hygiene results took place and the committee recommends the current hand hygiene compliance measures are not included in the dashboard going forward. Dr. Beeman will provide more detail on the Hand Hygiene improvement initiatives as a follow-up item for the next committee meeting. **Motion**: To receive the FY24 Enterprise Quality Dashboard **Movant**: Po **Second**: Chang **Ayes**: Somersille, Chang, Simon, Zoglin, Po, Legha, Ho **Noes**: None **Abstain**: None **Absent**: Sharma **Recused**: None	***Motion Approved***
8. RECEIVE FOLLOW-UP ITEM - HAC 2.0 WEIGHTING	Dr. Holly Beeman, CQO, provided information on the request from the committee to review the current weighting of each component of the HAC Index 2.0, with consideration to changing the weighting of the individual measures or potentially keeping them at their current weighting. After discussion amongst the committee and staff, a motion was made to change the weighting of the measures. **Motion**: To change the weighting of HAC Index 2.0 measures to 25%, for each measure	***Motion Approved*** ***Actions:*** *HAC 2.0 Index measures to be adjusted to be weighed at 25%, for each measure.*

	Movant: Somersille **Second**: Po **Ayes**: Somersille, Chang, Simon, Zoglin, Po, Legha, Ho **Noes**: None **Abstain**: None **Absent**: Sharma **Recused**: None	
9. RECEIVE PATIENT STORY	Cheryl Reinking, CNO, presented multiple nominations for the Daisy Award. The Daisy Award nominations are written by grateful patients or their families, each month, to highlight exceptional patient care they receive from El Camino Health staff. Ms. Reinking highlighted that two of the Daisy Award nominations were received from patients who described elements of what is included in the Press Ganey survey questions and exemplifies strong support that the ongoing patient experience training is reaching the patients of El Camino Health. **Motion**: To receive the Patient Story **Movant**: Po **Second**: Chang **Ayes**: Somersille, Chang, Simon, Zoglin, Po, Legha, Ho **Noes**: None **Abstain**: None **Absent**: Sharma **Recused**: None	***Motion Approved***
10. RECEIVE HEALTH EQUITY UPDATE	Dr. Holly Beeman, CQO, provided an update on Health Equity initiatives within the organization. Dr. Beeman highlighted work being done to optimize the tools (EPIC), workflows and training of staff to accurately collect patient reported information on race, language, and social determinants of health. A review of the Quality Council structure and reporting cadence was discussed including progress on having each department select one improvement measure viewed through a health equity lens. **Motion**: To receive Health Equity Update **Movant**: Simon **Second**: Po **Ayes**: Somersille, Chang, Simon, Zoglin, Po, Legha, Ho **Noes**: None **Abstain**: None **Absent**: Sharma **Recused**: None	***Motion Approved***
11. RECEIVE PSI REPORT	Dr. Holly Beeman, CQO, provided an update on the Patient Safety Indicators (PSIs) scores for FY23. Committee members discussed PSI-18/19, obstetrical laceration, and performance. ECH has a high ob laceration rate attributed to the high number of Asian patients who deliver at ECH. Asian women have a higher rate of obstetrical lacerations. Ms. Simon recalled having a detailed review of ECH obstetrical lacerations in a prior meeting. A follow-up item is to provide the detailed	***Motion Approved***

	earlier report on obstetrical lacerations to the committee for review at a future meeting. **Motion**: To receive FY2023 PSI report **Movant**: Simon **Second**: Po **Ayes**: Somersille, Chang, Simon, Zoglin, Po, Legha, Ho **Noes**: None **Abstain**: None **Absent**: Sharma **Recused**: None	
12. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session **Movant**: **Second**: **Ayes**: Somersille, Chang, Simon, Zoglin, Po, Legha, Ho **Noes**: None **Abstain**: None **Absent**: Sharma **Recused**: None	***Recessed to closed session at 6:43 p.m.***
13. AGENDA ITEM 18: CLOSED SESSION REPORT OUT	During the closed session, the Quality Committee approved the recommendation of the Credentialing and Privileges Report for approval by the El Camino Hospital Board of Directors, by a unanimous vote of all members present.	***Reconvened Open Session at 7:13 p.m.***
14. AGENDA ITEM 19: COMMITTEE ANNOUNCEMENTS	Chair Somersille recounted and confirmed action items for staff and the committee. No further announcements were made by the committee.	
15. AGENDA ITEM 20: ADJOURNMENT	**Motion**: To adjourn at 7:17 p.m. **Movant**: Po **Second**: Simon **Ayes**: Somersille, Chang, Simon, Zoglin, Po, Legha, Ho **Noes**: None **Abstain**: None **Absent**: Sharma **Recused**: None	***Adjourned at 7:17 p.m.***

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

APPROVED BY
QC 4/3/2023

Quality, Patient Care, and Patient Experience Committee
FY24 Pacing Plan

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 – OTHER REPORTS												
Quality & Safety Review of reportable events		✓			✓			✓			✓	
Board STEEP Dashboard Review		✓			✓			✓			✓	
El Camino Health Medical Network Report		✓			✓			✓			✓	
Annual Patient Safety Report			✓									
Annual Culture of Safety Survey Report			✓									
Patient Experience			✓						✓			
Health Care Equity						✓						✓
Safety Report for the Environment of Care					✓							
PSI Report						✓						
Sepsis Review						✓						
Value Based Purchasing Report									✓			
Approve Quality Assessment & Performance Improvement Plan (QAPI)												✓
Refresh STEEEP Dashboard measures for FY25			✓									
COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR												
Propose Committee Goals									✓			
Approve Committee Goals											✓	
Propose FY Committee Meeting dates									✓			
Approve FY Committee Meeting dates											✓	
Propose Organizational Goals									✓			
Approve Organizational Goals											✓	
Propose Pacing Plan									✓			
Approve Pacing Plan											✓	
Review Charter									✓			
Approve Charter											✓	

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), QC Follow Up Items, Patient Safety Report (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: February 5, 2024
Subject: December 5, 2023, Quality Committee Follow-up Item, Obstetrical Lacerations

Purpose:

To follow up on an item from the December 5, 2023, the Quality, Patient Care and Patient Experience Committee meeting.

Background:

Holly Beeman, CQO, provided an update on the Patient Safety Indicators (PSIs) scores for FY23 during the December 5th, 2023, Quality Committee meeting. Committee members discussed PSI-18/19, obstetrical laceration, and reviewed our performance. ECH has a high obstetrical laceration rate attributed to the high number of Asian patients who deliver at ECH (63% of all obstetrical patients). Asian women have a higher rate of obstetrical lacerations. Ms. Simon recalled having a detailed review of ECH obstetrical lacerations (PSI18/19) in a previous committee meeting. Attached to this cover memo is the PSI 18/19 Obstetrical Laceration report (memo and power point presentation) from June 1, 2020, Quality, Patient Care and Patient Experience Committee meeting for your review.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams MD CMO
Lisa Packard MD, Maternal Child Health Service Line Medical Director
Date: June 1, 2020
Subject: Patient Safety Indicator (PSI) Scores Q3 FY20 compared to FYTD Q1-Q3

Purpose: To provide an update on the AHRQ Patient Safety Indicators for Q3 FY20.

Summary:

1. Situation: The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth. These events are amenable to changes in the health care system or provider. The PSIs were developed after a comprehensive literature review, analysis of ICD-10-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.

2. Authority: Quality Committee of the Board is responsible for oversight of quality & safety.

3. Background: The PSIs can be used to help hospitals identify potential adverse events that might need further study; provide the opportunity to assess the incidence of adverse events and in-hospital complications using administrative data found in the typical discharge record; include indicators for complications occurring in hospital that may represent patient safety events; and, indicators also have area level analogs designed to detect patient safety events on a regional level.

4. Assessment: Each of the PSI are first reviewed and validated by the CDI manager and Coding manager, and are then sent through the Medical Staff's Peer review process for trending by physician. 7 of the 17 PSIs are over the Premier Mean for Q3 2020; with 5 PSIs with only 1,2 or 3 patients. These PSIs are: Death in Surgical Pts. with Treatable Complications, Postoperative Acute Kidney Injury Requiring Dialysis, In-hospital fall with Fracture, Postop Respiratory Failure, Unrecognized Abdominopelvic Accidental Puncture or Laceration, OB Trauma Vaginal Delivery with Instrument and OB Trauma Vaginal Delivery without Instrument. The committee has focused on the vaginal trauma PSI's in the past and requested additional information which will be provided at this meeting.

5. Other Reviews: None.

6. Outcomes: None.

List of Attachments:

1. Patient Safety Indicator (PSI) Scores Q3 FY20 compared to FYTD Q1-Q3 2020.
2. PSI 18 & 19: OB Perineal Laceration Report

Suggested Committee Discussion Questions: None

Patient Safety Indicator Report (AHRQ)

FY20 Q3 compared to FYTD Q1-Q3

Rate

Patient Safety Indicator		Numerator (FY20, Q3)	Denominator (FY20, Q3)	Rate/1000 (FY20 Q3)	Premier Mean*	Numerator (FY20, Q1-3)	Denominator (FY20, Q1-3)	Rate/1000 (FY20 Q1-3)	Premier Mean*
PSI-02	Death in Low Mortality DRGs	0	158	0.00	0.54	0	554	0.00	0.54
PSI-03	Pressure Ulcer	0	1,979	0.00	0.46	3	5,607	0.54	0.46
PSI-04	Death in Surgical Pts w Treatable Complications	3	19	157.89	120.99	10	76	131.58	120.99
PSI-06	Iatrogenic Pneumothorax	0	3,102	0.00	0.14	2	9,405	0.21	0.14
PSI-07	Central Venous Catheter-Related Blood Stream Infection	0	2,626	0.00	0.10	0	8,105	0.00	0.10
PSI-08	In Hospital Fall with Hip Fracture	1	2,659	0.38	0.10	2	7,991	0.25	0.10
PSI-09	Perioperative Hemorrhage or Hematoma	1	940	1.06	1.84	2	3,170	0.63	1.84
PSI-10	Postoperative Acute Kidney Injury Requiring Dialysis	1	548	1.82	0.75	1	1,914	0.52	0.75
PSI-11	Postop Respiratory Failure	2	423	4.73	4.18	2	1,569	1.27	4.18
PSI-12	Perioperative PE or DVT	0	977	0.00	2.61	5	3,310	1.51	2.61
PSI-13	Postop Sepsis	1	534	1.87	3.46	4	1,899	2.11	3.46
PSI-14	Postop Wound Dehiscence	0	308	0.00	0.65	0	985	0.00	0.65
PSI-15	Unrecognized Abdominopelvic Accidental Puncture or Laceration	3	797	3.76	0.82	5	2,506	2.00	0.82
PSI-17	Birth Trauma Injury to Neonate	3	1,013	2.96	4.02	14	3,277	4.27	4.02
PSI-18	OB Trauma Vaginal Delivery with Instrument	14	66	212.12	107.66	33	180	183.33	107.66
PSI-19	OB Trauma Vaginal Delivery without Instrument	15	662	22.66	15.45	67	2,135	31.38	15.45

Count Measures

Patient Safety Indicator		Cases (FY20 Q3)	Premier Mean Cases*	Cases (FY20 Q1-3)	Premier Mean Cases*
PSI-05	Retained Surgical Item or Unretrieved Device Fra	0	0.16	0.00	0.16

Source: Quality Advisor 5/20/20

El Camino Health

PSI 18 &19: OB Perineal Laceration Report

Quality Committee of the Board
June 2020
Maternal Child Health Service Line

OB Perineal Injury Taskforce Team Members

- Dr. Lisa Packard, Medical Director, OB
- Dr. Linda Teagle, Los Gatos Chief of Staff
- Dr. Alissa Erogbogbo, Vice Chief OB/GYN LG
- Dr. Lynn Gretkowski, Medical Director, OB Hospitalists
- Dr. Dr. Kavitha Raj, Chief OB/GYN MV
- Dr. Marty Halum, OB Anesthesia
- Maria Greulich, Certified Nurse Midwife
- Lin Lee, Certified Nurse Midwife
- Brittney Wood, Certified Nurse Midwife
- Christine Borden, Certified Nurse Midwife
- Ellen Keohane, Nurse Educator OB
- Indira McKay, MV L&D Clinical Manager
- Meriam Signo, Director Patient Care Services LG
- Leslie Vazquez, MCH SL Coordinator, OB Concierge
- Tony Liu, MCH Service Line Operations Specialist
- Heather Freeman, Sr. Director Service Lines

Action Steps Since January 2020 Report: A3 Problem Solving with OB Perineal Injury Task Force

Current State and Problem Analysis

- Analyzed FY19 lacerations, trends
- Developed Epic lacerations report
- Analyzed FY20 performance through April, by volume, by provider, by problem
- Additional chart reviews, literature review, cause analysis

- Countermeasures:
  - Developed process for warm compress, developing documentation
  - Engaged Stanford for education/ discussion: May 29
  - Developing nutritional guide for vegetarian/vegan pregnant women
    - South Asian Heart Center partnership
  - Distributing unblinded data and information in May again
  - Vaginal dilator study: summer
  - Exploring episiotomy improvements
  - Individual provider support and follow up

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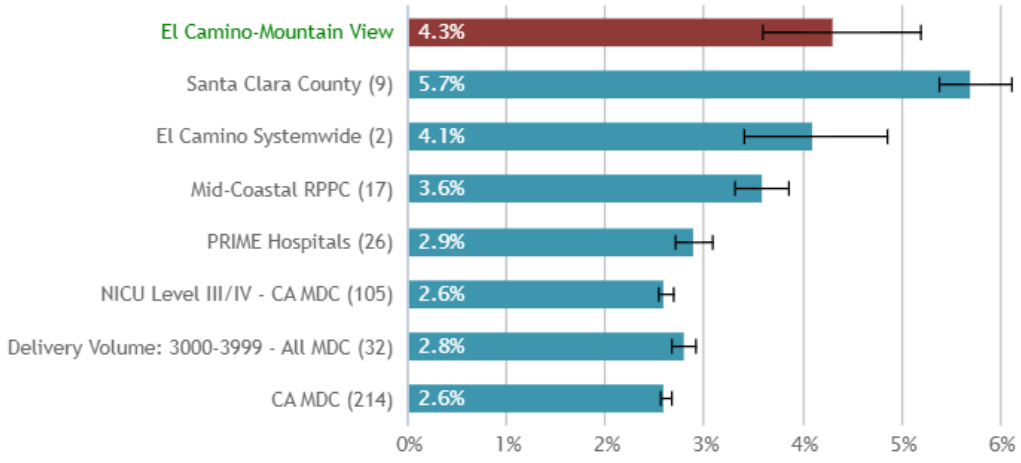
PSI 18 and 19 Performance:
Above National Average, Below Santa Clara County Average

National Performance: Patient Safety Indicator Report, Quality Advisor

Patient Safety Indicator		Numerator (FY20, Q3)	Denominator (FY20, Q3)	Rate/1000 (FY20 Q3)	Premier Mean*	Numerator (FY20, Q1-3)	Denominator (FY20, Q1-3)	Rate/1000 (FY20 Q1-3)	Premier Mean*
PSI-18	OB Trauma Vaginal Delivery with Instrument	14	66	212.12	107.66	33	180	183.33	107.66
PSI-19	OB Trauma Vaginal Delivery without Instrument	15	662	22.66	15.45	67	2,135	31.38	15.45

California Performance: CMQCC

- 3rd and 4th degree laceration, all vaginal deliveries, Apr 2019-Mar 2020, peer comparison



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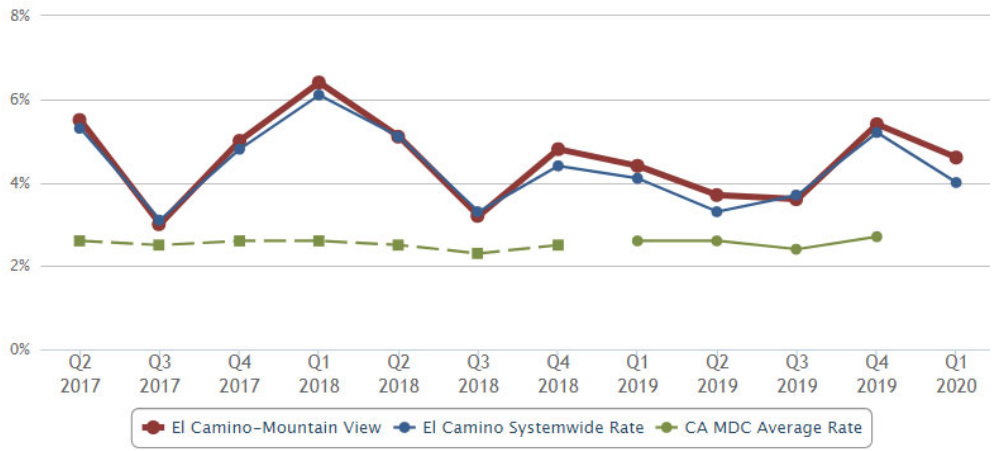
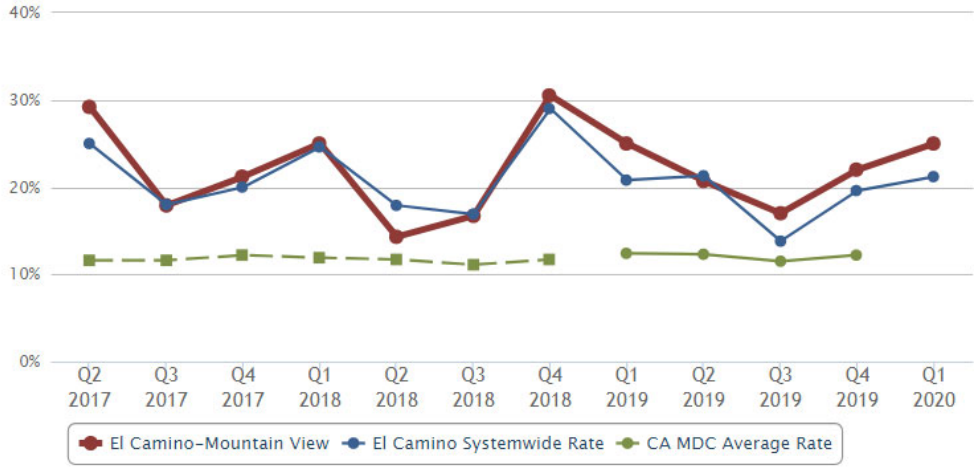
Performance Over Time: 2017 Q2 - 2020 Q1

3rd and 4th Degree Laceration, All



- 3rd and 4th Degree Laceration with Instrument



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3rd and 4th Degree Lacerations Analysis FY20 thru April

- Total 3rd and 4th degree lacerations: 110
  - **3rd degree: 90%** (99)
  - 4th degree 10% (11)
- Delivery types
  - Inductions: 34.5% (38)
  - **Spontaneous delivery: 72%** (79)
    - Vaginal breech: 1
- Instruments
  - **Vac-assist delivery: 33%** (36)
  - Forceps delivery: 1.8% (2)
- Episiotomy: 15% (17)
  - **Medial: 11** (10 = 3rd degree)
  - Medial-lateral: 6 (all 3rd degree)
  - No documentation: 9
  - Documented indications for episiotomy:
    - Instrumented Delivery: 9
    - Fetal intolerance of labor:7
    - Shoulder dystocia: 4
    - Macrosomia: 1

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ACOG Practice Bulletin 2016: Prevention and Management of Obstetric Lacerations

- **Strongest risk factors:** based on a 22 study meta-analysis
  - Forceps delivery, **vacuum assisted delivery** (increased if has episiotomy)
  - Increased fetal birth weight
- Other risk factors:
  - Primiparity (first baby)
  - **Asian ethnicity**
  - Labor induction or augmentation
  - Epidural
  - Occiput posterior fetal position

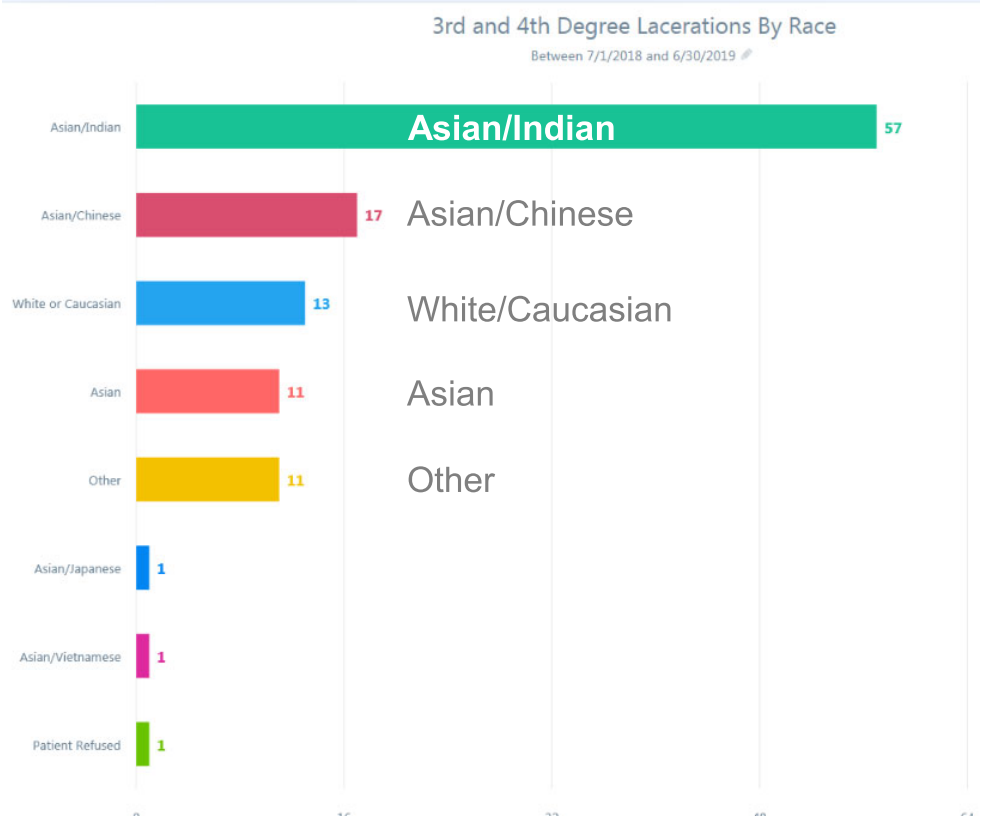
- **Recommendations**:
  - Level A Evidence:
    - Use **warm perineal compresses** intrapartum
    - **Decrease use of episiotomy, instrumentation**
  - Level B Evidence:
    - Perineal massage intrapartum
    - **Consider medial-lateral episiotomy**

2016 ACOG Committee Opinion #647:
Limitations of Perineal Lacerations as an Obstetric Quality Measure
Not recommended as quality measure due to variable definitions, mostly non-modifiable risk factors, and reducing rate likely to result in increased C-sections

El Camino Health

Risk Factor: Asian Ethnicity

- 64% Asian OB population at ECH MV
- 76% of 3rd and 4th degree lacerations at ECH are in the Asian population
- Perineal Body Length:
  - Asian population has shortest perineal body length, therefore the greatest risk for 3rd/4th degree laceration
    - Yeaton-Massey et al., 2015; Deering et al., 2004



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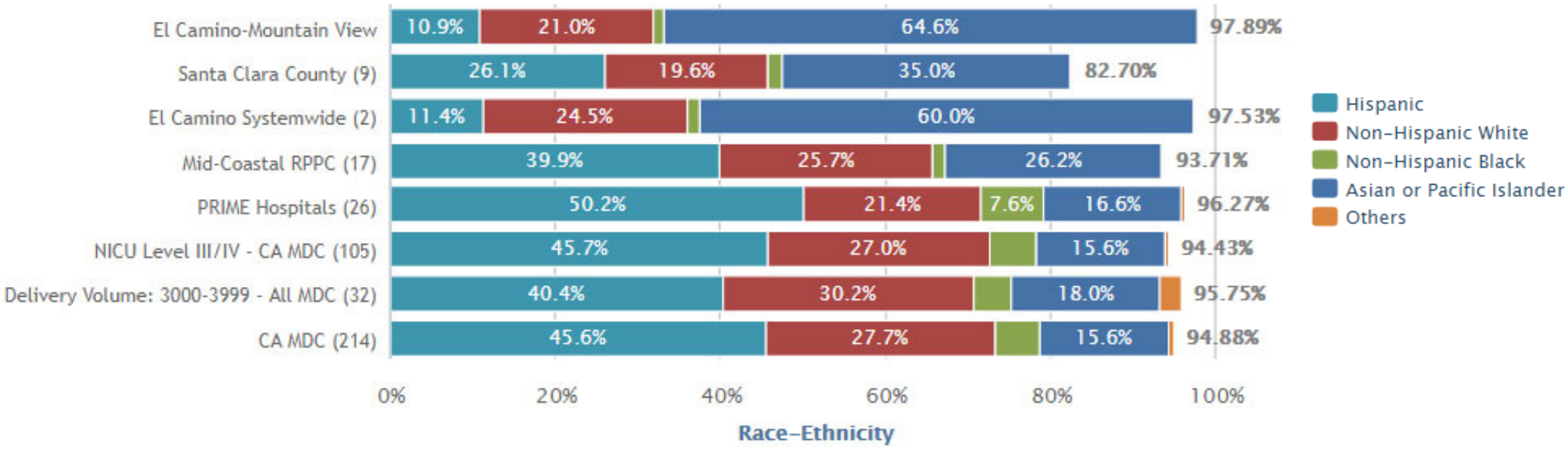
ECH MV Asian Population is 4x the California Average



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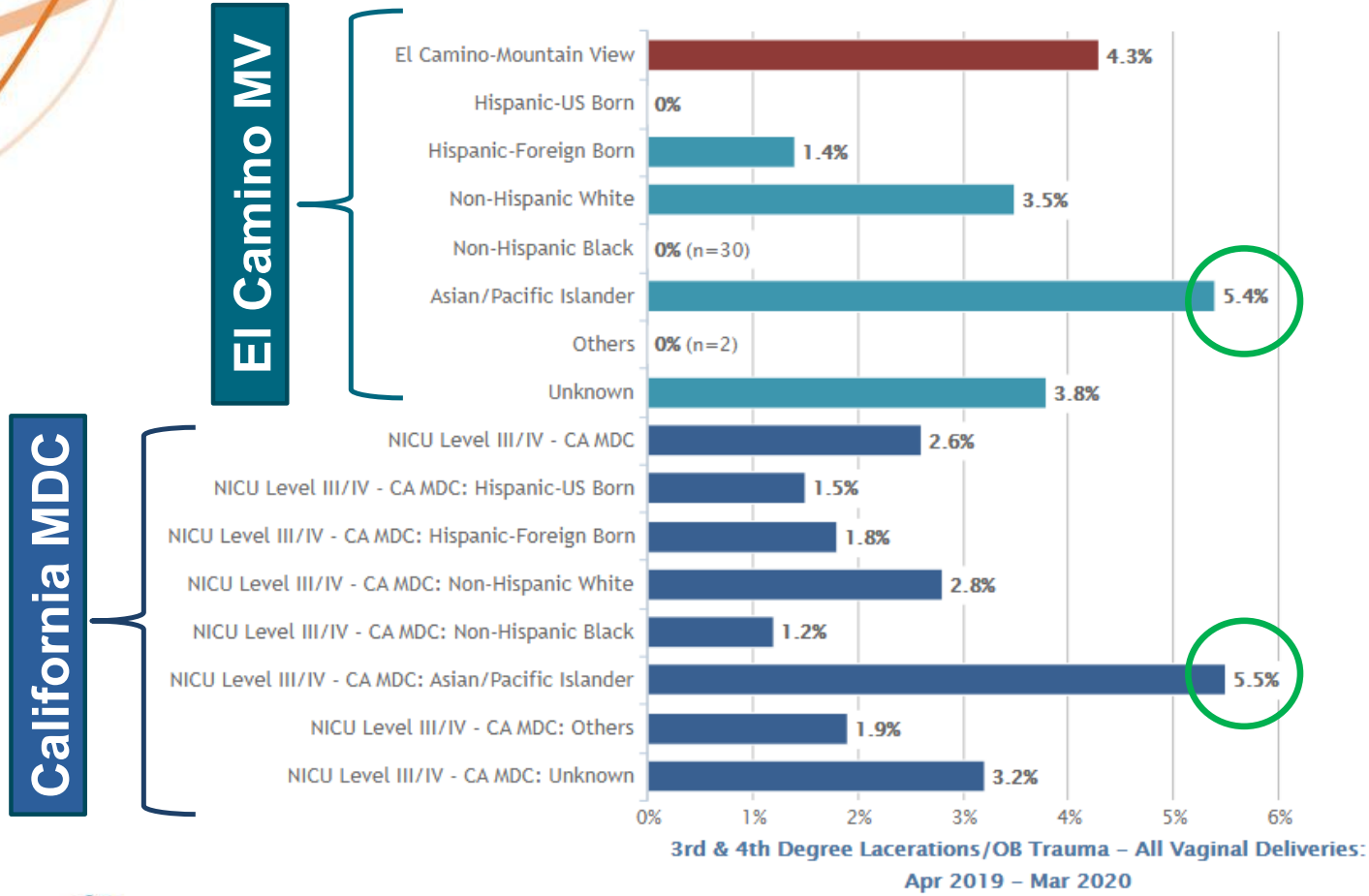

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CA Asian/Pacific Islander **risk of laceration is 2X higher than the average**

- CA overall rate: 2.6%
- CA Asian/Pacific Islander rate: 5.5%
- ECH MV Asian/Pacific Islander rate: 5.4% (89/1659)

ECH performs at average for Asian/Pacific Islander Population

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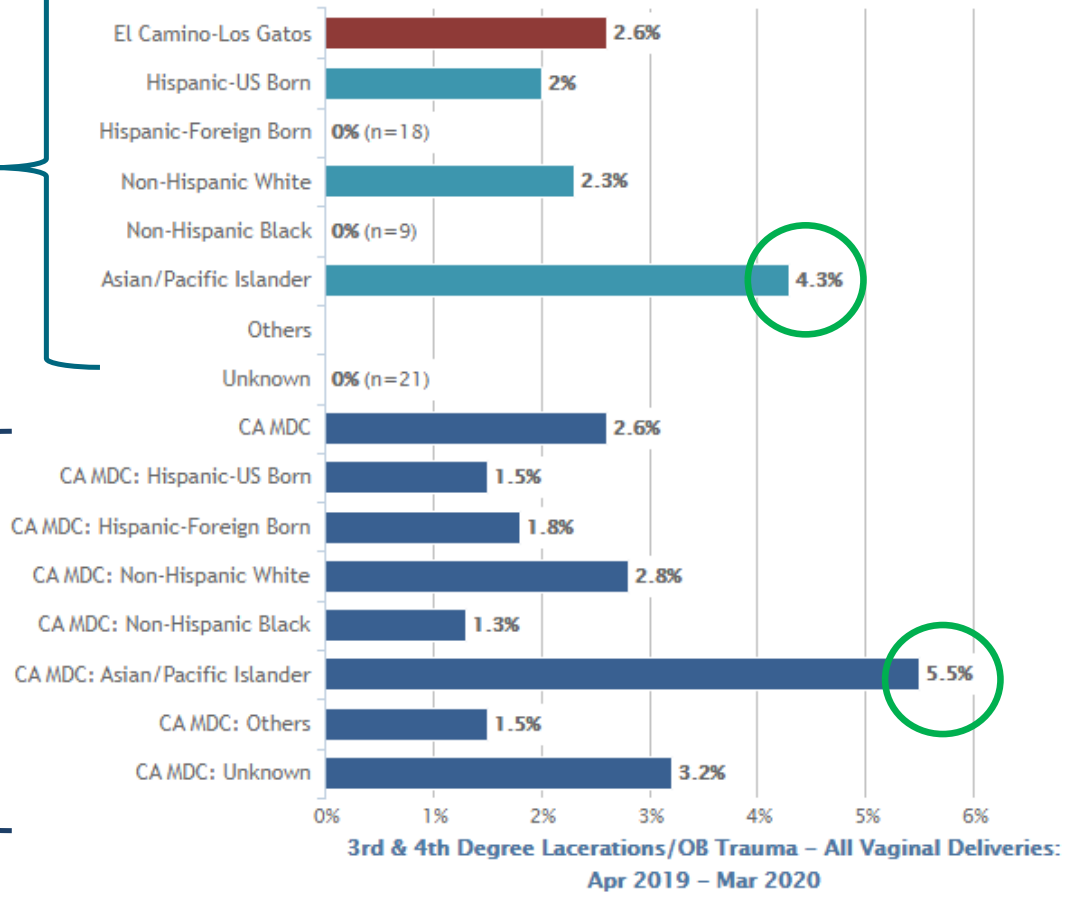
California MDC



3rd & 4th Degree Lacerations/OB Trauma – All Vaginal Deliveries: Apr 2019 – Mar 2020

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Los Gatos Campus 3rd and 4th degree laceration rate is average, with Asian/Pacific Islander population performing worse, similar to CA

- CA overall rate: 2.6%
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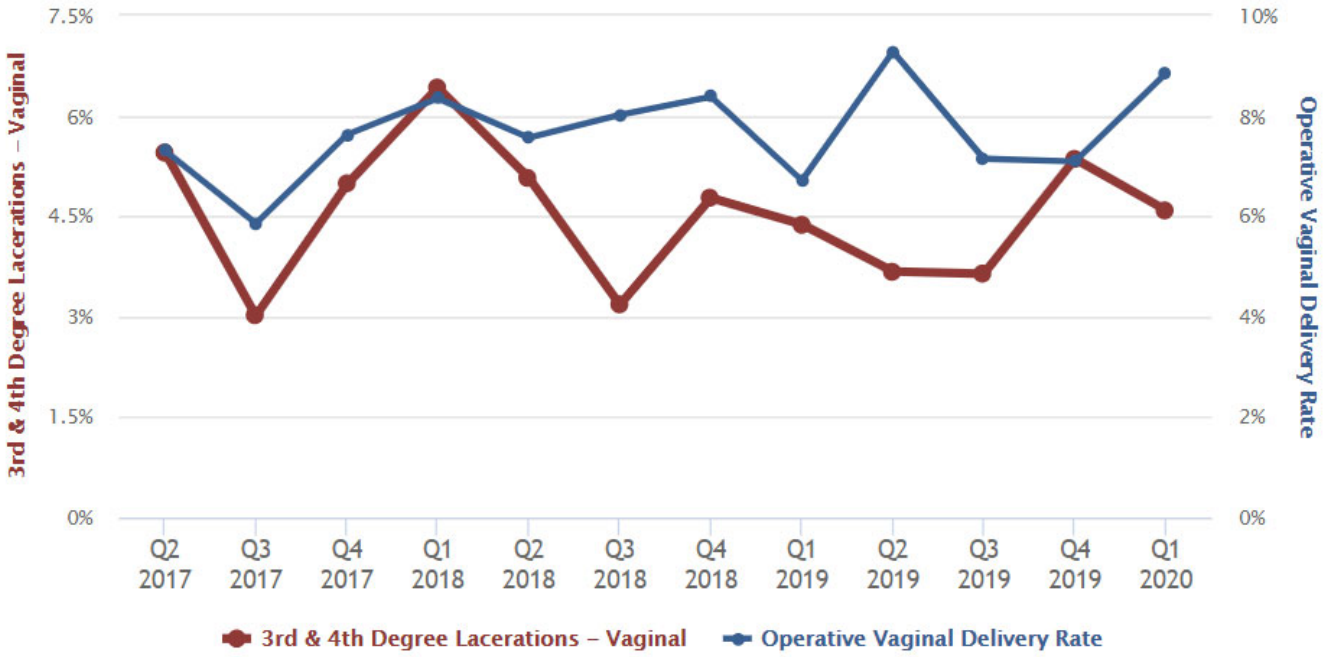
- ECH LG Asian/Pacific Islander rate: 4.3% (6/139)

Risk Factor: Operative Vaginal Delivery



- Although operative vaginal delivery is a risk factor for laceration, it has not correlated tightly with laceration rate.
- Operative vaginal delivery is used to avoid C/S delivery

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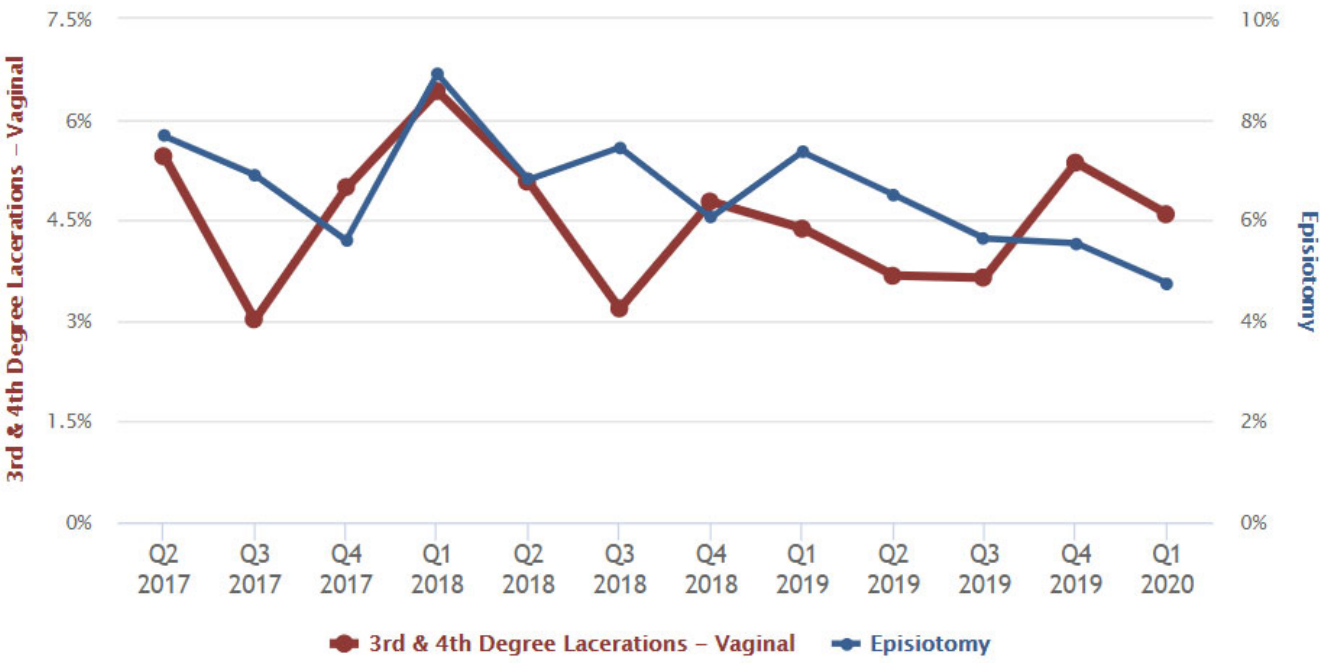
Risk Factors: Episiotomy



- Episiotomy tends to trend more closely with laceration rates.
- ECH episiotomy rate is 1% higher than CA average
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- Opportunity to improve

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Initiatives to Decrease OB Trauma

- Review low and high rate providers, learn best practices, support improvement
- Improve use of episiotomy and type; provider support
- Document and track warm compresses use
- Develop recommendations for management of perineum/perineal massage
- Develop nutrition recommendations/support for vegetarian/vegan women
- Trial slow vaginal dilation device intrapartum (NIH trial, Materna, Dr. Azad PI): Summer
- Education and discussion forum with midwives and Stanford OB: May 2020
- Distribute unblinded data and information

- **Target: Improve MV 3rd and 4th degree laceration with instrument by 15% from 22.2% to 18.9% on MV campus by July 1, 2020; FYTD = 21.6%**

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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: February 5, 2024
Subject: December 5, 2023, Quality Committee Follow-up Item, Obstetrical Lacerations

Purpose:

To follow up on an item from the December 5, 2023, the Quality, Patient Care and Patient Experience Committee meeting.

Background:

Holly Beeman, CQO, provided an update on the Patient Safety Indicators (PSIs) scores for FY23 during the December 5th, 2023, Quality Committee meeting. Committee members discussed PSI-18/19, obstetrical laceration, and reviewed our performance. ECH has a high obstetrical laceration rate attributed to the high number of Asian patients who deliver at ECH (63% of all obstetrical patients). Asian women have a higher rate of obstetrical lacerations. Ms. Simon recalled having a detailed review of ECH obstetrical lacerations (PSI18/19) in a previous committee meeting. Attached to this cover memo is the PSI 18/19 Obstetrical Laceration report (memo and power point presentation) from June 1, 2020, Quality, Patient Care and Patient Experience Committee meeting for your review.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams MD CMO
Lisa Packard MD, Maternal Child Health Service Line Medical Director
Date: June 1, 2020
Subject: Patient Safety Indicator (PSI) Scores Q3 FY20 compared to FYTD Q1-Q3

Purpose: To provide an update on the AHRQ Patient Safety Indicators for Q3 FY20.

Summary:

1. Situation: The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth. These events are amenable to changes in the health care system or provider. The PSIs were developed after a comprehensive literature review, analysis of ICD-10-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.

2. Authority: Quality Committee of the Board is responsible for oversight of quality & safety.

3. Background: The PSIs can be used to help hospitals identify potential adverse events that might need further study; provide the opportunity to assess the incidence of adverse events and in-hospital complications using administrative data found in the typical discharge record; include indicators for complications occurring in hospital that may represent patient safety events; and, indicators also have area level analogs designed to detect patient safety events on a regional level.

4. Assessment: Each of the PSI are first reviewed and validated by the CDI manager and Coding manager, and are then sent through the Medical Staff's Peer review process for trending by physician. 7 of the 17 PSIs are over the Premier Mean for Q3 2020; with 5 PSIs with only 1,2 or 3 patients. These PSIs are: Death in Surgical Pts. with Treatable Complications, Postoperative Acute Kidney Injury Requiring Dialysis, In-hospital fall with Fracture, Postop Respiratory Failure, Unrecognized Abdominopelvic Accidental Puncture or Laceration, OB Trauma Vaginal Delivery with Instrument and OB Trauma Vaginal Delivery without Instrument. The committee has focused on the vaginal trauma PSI's in the past and requested additional information which will be provided at this meeting.

5. Other Reviews: None.

6. Outcomes: None.

List of Attachments:

1. Patient Safety Indicator (PSI) Scores Q3 FY20 compared to FYTD Q1-Q3 2020.
2. PSI 18 & 19: OB Perineal Laceration Report

Suggested Committee Discussion Questions: None

Patient Safety Indicator Report (AHRQ)

FY20 Q3 compared to FYTD Q1-Q3

Rate

Patient Safety Indicator		Numerator (FY20, Q3)	Denominator (FY20, Q3)	Rate/1000 (FY20 Q3)	Premier Mean*	Numerator (FY20, Q1-3)	Denominator (FY20, Q1-3)	Rate/1000 (FY20 Q1-3)	Premier Mean*
PSI-02	Death in Low Mortality DRGs	0	158	0.00	0.54	0	554	0.00	0.54
PSI-03	Pressure Ulcer	0	1,979	0.00	0.46	3	5,607	0.54	0.46
PSI-04	Death in Surgical Pts w Treatable Complications	3	19	157.89	120.99	10	76	131.58	120.99
PSI-06	Iatrogenic Pneumothorax	0	3,102	0.00	0.14	2	9,405	0.21	0.14
PSI-07	Central Venous Catheter-Related Blood Stream Infection	0	2,626	0.00	0.10	0	8,105	0.00	0.10
PSI-08	In Hospital Fall with Hip Fracture	1	2,659	0.38	0.10	2	7,991	0.25	0.10
PSI-09	Perioperative Hemorrhage or Hematoma	1	940	1.06	1.84	2	3,170	0.63	1.84
PSI-10	Postoperative Acute Kidney Injury Requiring Dialysis	1	548	1.82	0.75	1	1,914	0.52	0.75
PSI-11	Postop Respiratory Failure	2	423	4.73	4.18	2	1,569	1.27	4.18
PSI-12	Perioperative PE or DVT	0	977	0.00	2.61	5	3,310	1.51	2.61
PSI-13	Postop Sepsis	1	534	1.87	3.46	4	1,899	2.11	3.46
PSI-14	Postop Wound Dehiscence	0	308	0.00	0.65	0	985	0.00	0.65
PSI-15	Unrecognized Abdominopelvic Accidental Puncture or Laceration	3	797	3.76	0.82	5	2,506	2.00	0.82
PSI-17	Birth Trauma Injury to Neonate	3	1,013	2.96	4.02	14	3,277	4.27	4.02
PSI-18	OB Trauma Vaginal Delivery with Instrument	14	66	212.12	107.66	33	180	183.33	107.66
PSI-19	OB Trauma Vaginal Delivery without Instrument	15	662	22.66	15.45	67	2,135	31.38	15.45

Count Measures

Patient Safety Indicator		Cases (FY20 Q3)	Premier Mean Cases*	Cases (FY20 Q1-3)	Premier Mean Cases*
PSI-05	Retained Surgical Item or Unretrieved Device Fra	0	0.16	0.00	0.16

Source: Quality Advisor 5/20/20

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PSI 18 &19: OB Perineal Laceration Report

Quality Committee of the Board
June 2020
Maternal Child Health Service Line

OB Perineal Injury Taskforce Team Members

- Dr. Lisa Packard, Medical Director, OB
- Dr. Linda Teagle, Los Gatos Chief of Staff
- Dr. Alissa Erogbogbo, Vice Chief OB/GYN LG
- Dr. Lynn Gretkowski, Medical Director, OB Hospitalists
- Dr. Dr. Kavitha Raj, Chief OB/GYN MV
- Dr. Marty Halum, OB Anesthesia
- Maria Greulich, Certified Nurse Midwife
- Lin Lee, Certified Nurse Midwife
- Brittney Wood, Certified Nurse Midwife
- Christine Borden, Certified Nurse Midwife
- Ellen Keohane, Nurse Educator OB
- Indira McKay, MV L&D Clinical Manager
- Meriam Signo, Director Patient Care Services LG
- Leslie Vazquez, MCH SL Coordinator, OB Concierge
- Tony Liu, MCH Service Line Operations Specialist
- Heather Freeman, Sr. Director Service Lines

Action Steps Since January 2020 Report: A3 Problem Solving with OB Perineal Injury Task Force

Current State and Problem Analysis

- Analyzed FY19 lacerations, trends
- Developed Epic lacerations report
- Analyzed FY20 performance through April, by volume, by provider, by problem
- Additional chart reviews, literature review, cause analysis

- Countermeasures:
  - Developed process for warm compress, developing documentation
  - Engaged Stanford for education/ discussion: May 29
  - Developing nutritional guide for vegetarian/vegan pregnant women
    - South Asian Heart Center partnership
  - Distributing unblinded data and information in May again
  - Vaginal dilator study: summer
  - Exploring episiotomy improvements
  - Individual provider support and follow up

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PSI 18 and 19 Performance:
Above National Average, Below Santa Clara County Average

National Performance: Patient Safety Indicator Report, Quality Advisor

Patient Safety Indicator		Numerator (FY20, Q3)	Denominator (FY20, Q3)	Rate/1000 (FY20 Q3)	Premier Mean*	Numerator (FY20, Q1-3)	Denominator (FY20, Q1-3)	Rate/1000 (FY20 Q1-3)	Premier Mean*
PSI-18	OB Trauma Vaginal Delivery with Instrument	14	66	212.12	107.66	33	180	183.33	107.66
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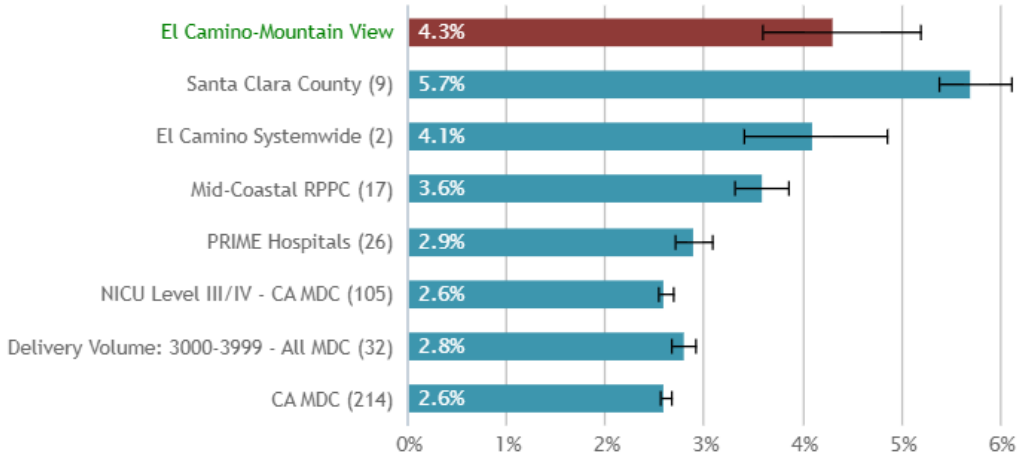
California Performance: CMQCC

- 3rd and 4th degree laceration, all vaginal deliveries, Apr 2019-Mar 2020, peer comparison



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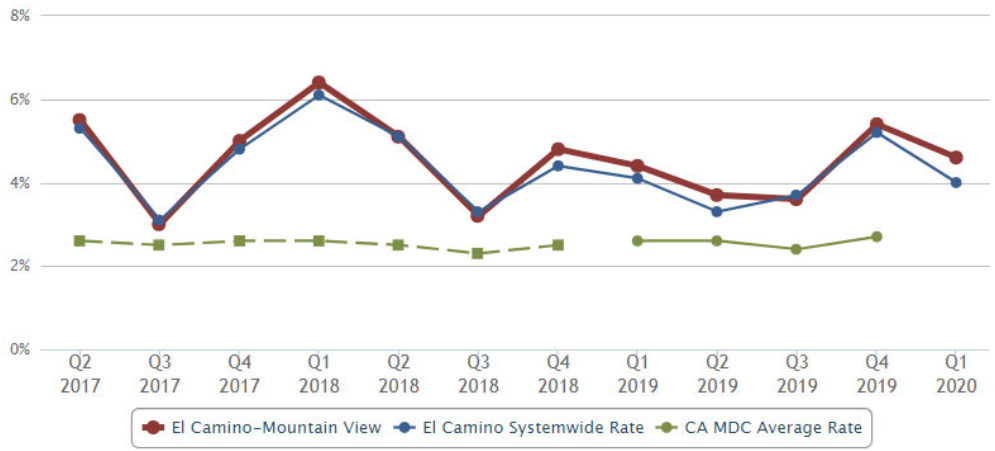
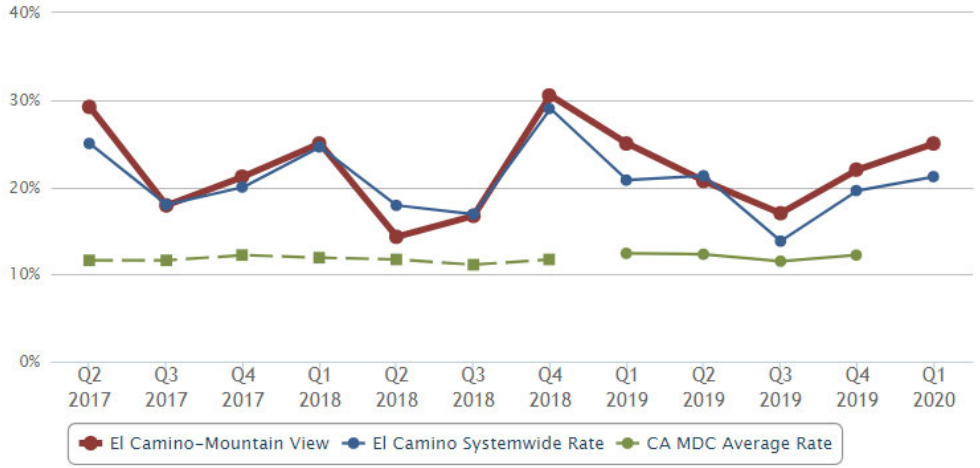
Performance Over Time: 2017 Q2 - 2020 Q1

3rd and 4th Degree Laceration, All



- 3rd and 4th Degree Laceration with Instrument



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3rd and 4th Degree Lacerations Analysis FY20 thru April

- Total 3rd and 4th degree lacerations: 110
  - **3rd degree: 90%** (99)
  - 4th degree 10% (11)
- Delivery types
  - Inductions: 34.5% (38)
  - **Spontaneous delivery: 72%** (79)
    - Vaginal breech: 1
- Instruments
  - **Vac-assist delivery: 33%** (36)
  - Forceps delivery: 1.8% (2)

- Episiotomy: 15% (17)
  - **Medial: 11** (10 = 3rd degree)
  - Medial-lateral: 6 (all 3rd degree)
  - No documentation: 9
  - Documented indications for episiotomy:
    - Instrumented Delivery: 9
    - Fetal intolerance of labor:7
    - Shoulder dystocia: 4
    - Macrosomia: 1

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ACOG Practice Bulletin 2016: Prevention and Management of Obstetric Lacerations

- **Strongest risk factors:** based on a 22 study meta-analysis
  - Forceps delivery, **vacuum assisted delivery** (increased if has episiotomy)
  - Increased fetal birth weight
- Other risk factors:
  - Primiparity (first baby)
  - **Asian ethnicity**
  - Labor induction or augmentation
  - Epidural
  - Occiput posterior fetal position

- **Recommendations**:
  - Level A Evidence:
    - Use **warm perineal compresses** intrapartum
    - **Decrease use of episiotomy, instrumentation**
  - Level B Evidence:
    - Perineal massage intrapartum
    - **Consider medial-lateral episiotomy**

2016 ACOG Committee Opinion #647:
Limitations of Perineal Lacerations as an Obstetric Quality Measure
Not recommended as quality measure due to variable definitions, mostly non-modifiable risk factors, and reducing rate likely to result in increased C-sections

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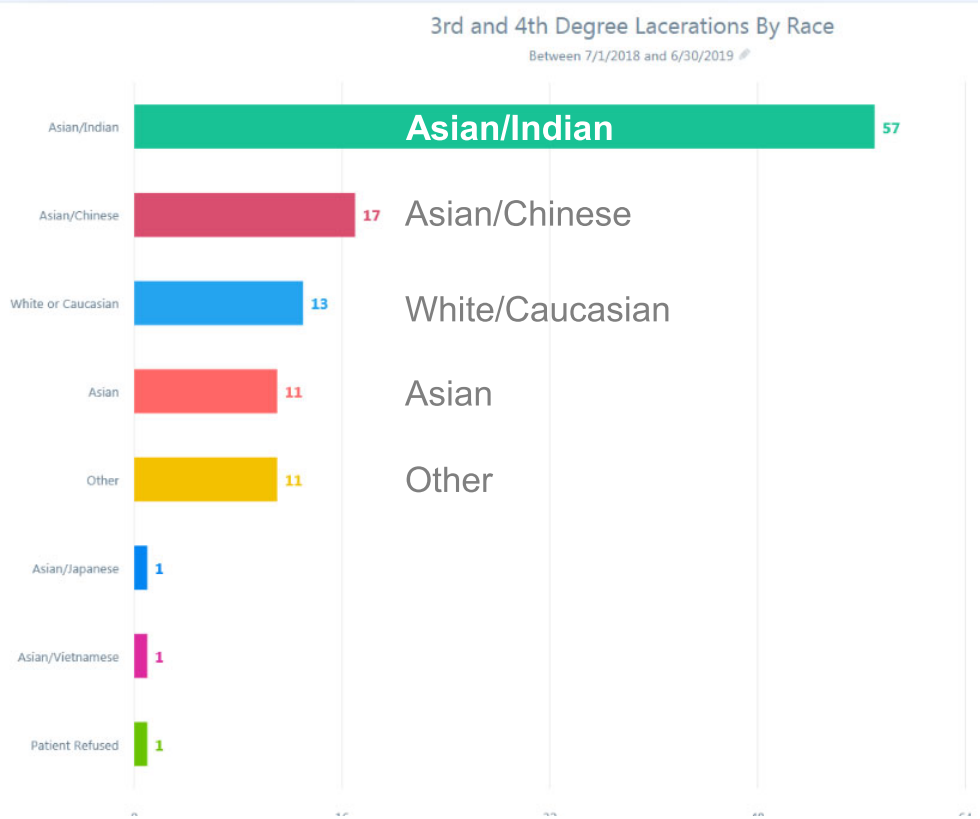
Risk Factor: Asian Ethnicity

- 64% Asian OB population at ECH MV
- 76% of 3rd and 4th degree lacerations at ECH are in the Asian population
- Perineal Body Length:
  - Asian population has shortest perineal body length, therefore the greatest risk for 3rd/4th degree laceration
    - Yeaton-Massey et al., 2015; Deering et al., 2004



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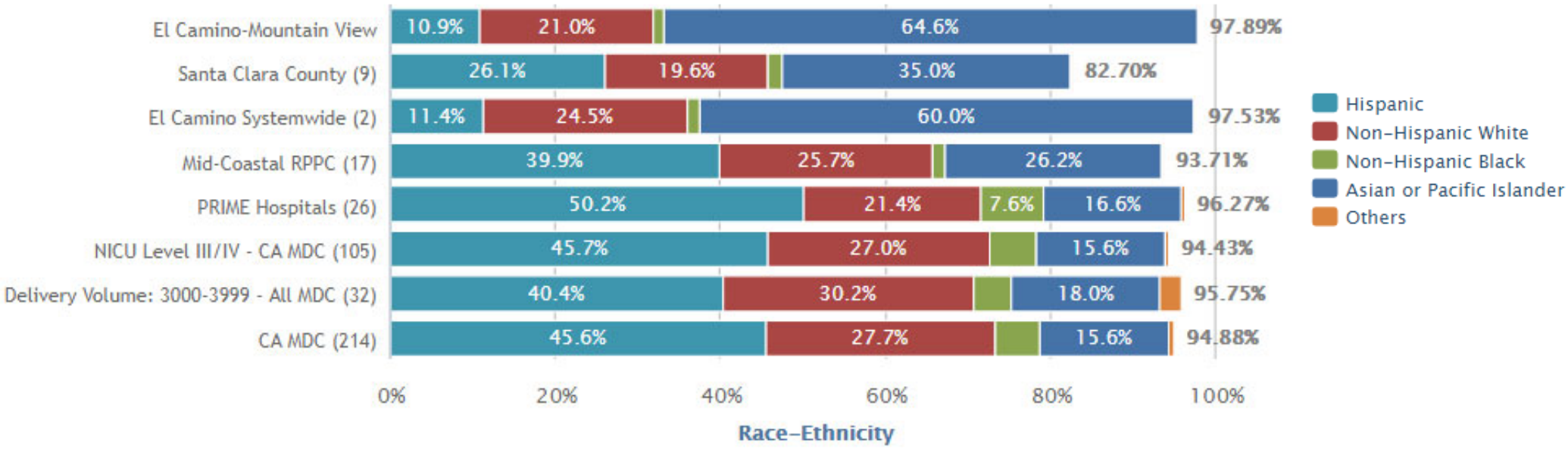

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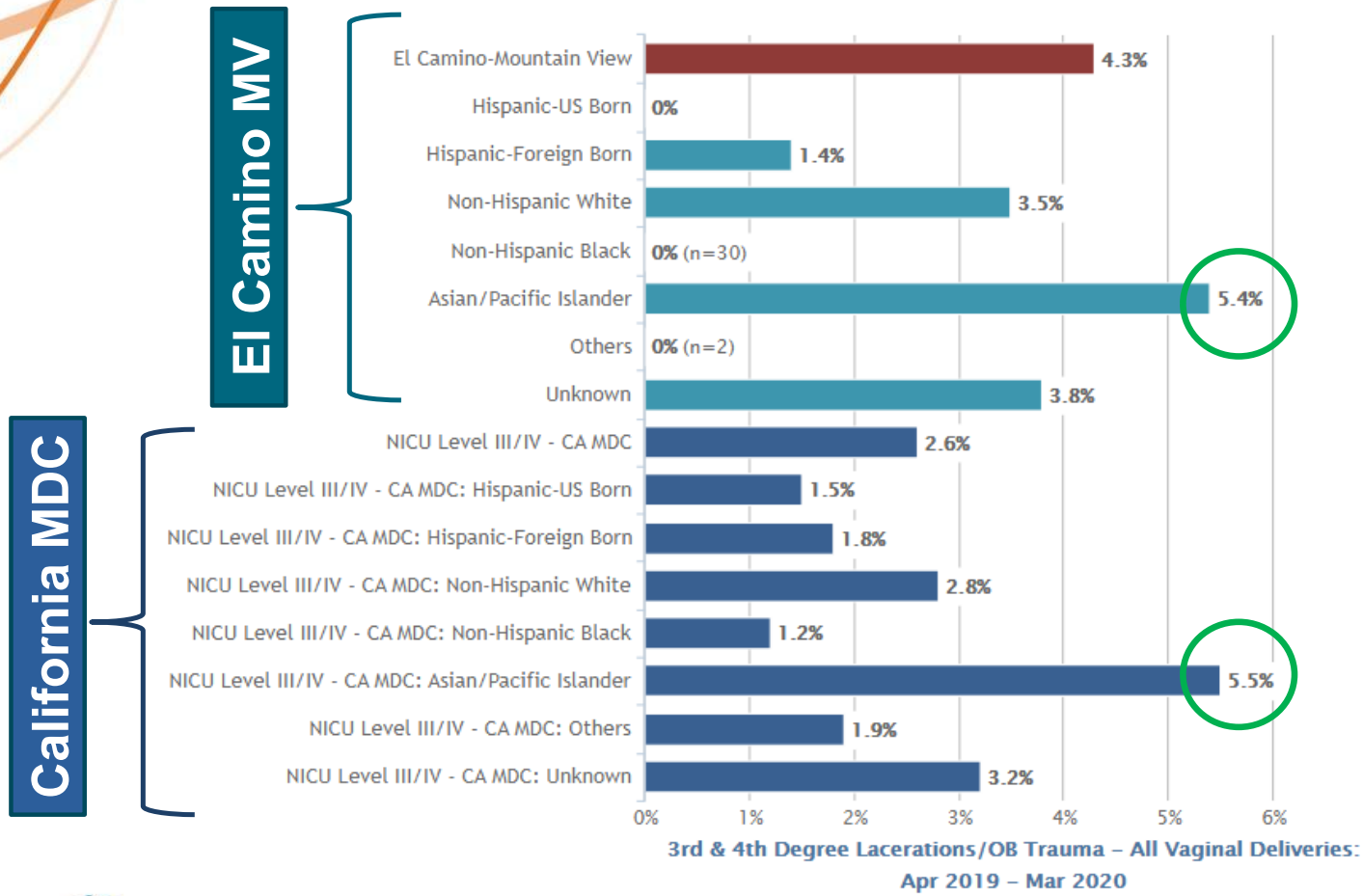

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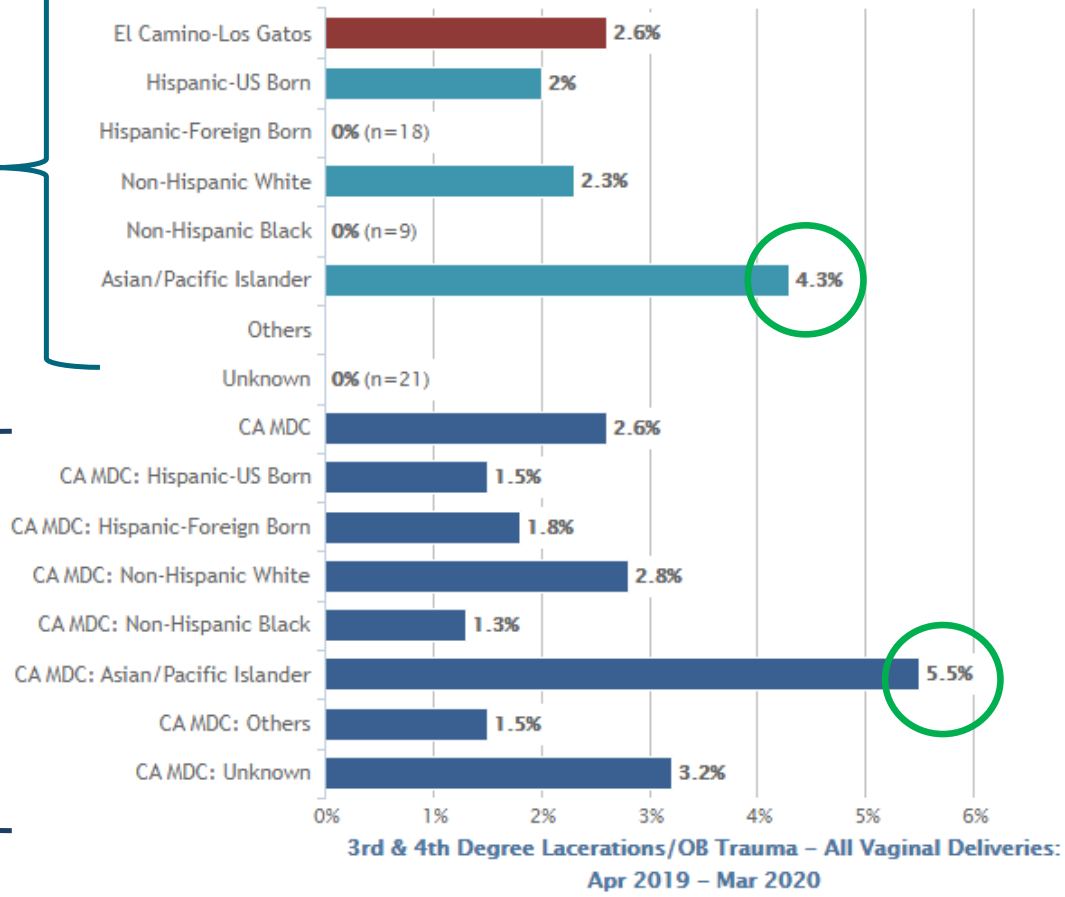

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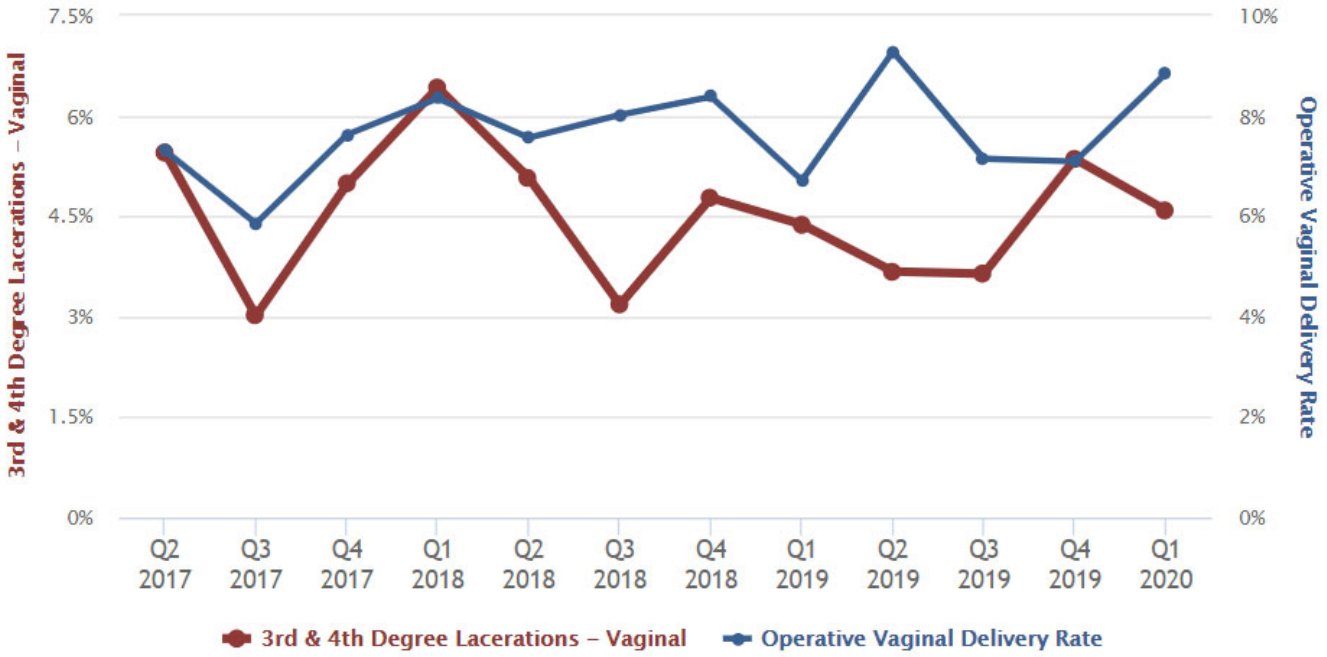

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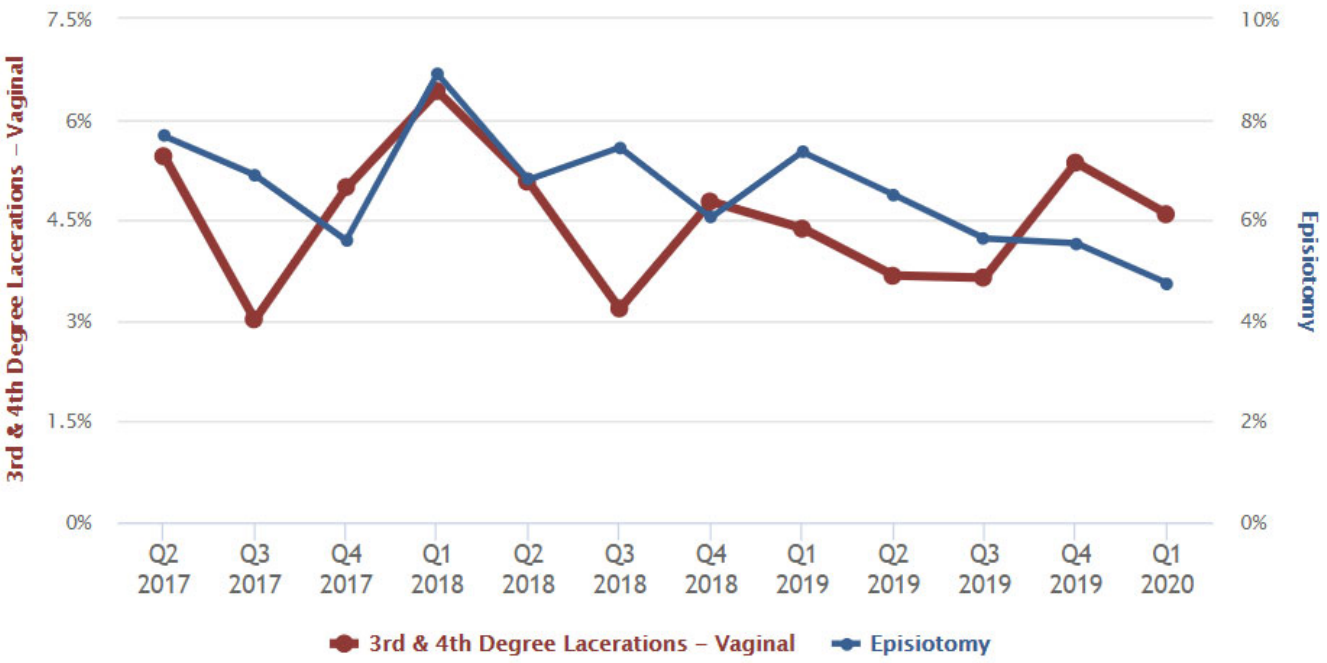
Risk Factors: Episiotomy



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

To: Quality, Patient Care, and Patient Experience Committee
From: Lyn Garrett, Senior Director, Quality Department
Date: February 5, 2024
Subject: Hand Hygiene Process Improvement

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on the Hand Hygiene Process Improvement activities.

Recommendation:

Informational only.

Summary: Hand Hygiene is the number one tool to reduce hospital acquired infections. ECH wants to evaluate and update our Hand Hygiene program to optimize our auditing process to ensure and improve compliance with hand hygiene.

1. Situation: ECH Hand Hygiene program needs to be evaluated and redesigned to achieve a sustained improvement in hand hygiene compliance.

2. Background: Hand hygiene is vital for the safety of our patients and staff. Audits of hand hygiene practice is necessary to track compliance as a mandatory element of Leapfrog reporting, as a requirement dictated by TJC, and as an integral part of our enterprise-wide hand hygiene program.

We've had several past initiatives focused on hand hygiene, most recently in FY23. Prior initiatives have improved compliance, but only for a limited time (2-3 months). This is similar to the experience of other health systems. Medical literature is rife with publications demonstrating a short-lived improvement in hand hygiene following an enterprise-wide campaign. The average hand hygiene compliance rate has been reported as 40% in high-income countries like the United States. (Lotfinejad N, 2021)

Problem Statement:
We do not have a robust hand hygiene program and have inconsistent practices of performing hand hygiene audits, and poor hand hygiene compliance based on the limited number of audits performed. Having hospital acquired C.diff infections in low risk patients who are in proximity to patients in isolation who are colonized with C. Diff suggests our hand hygiene compliance is not optimal.

3. Assessment: ECH has an opportunity to improve the Hand Hygiene program (auditing and compliance), Leapfrog has developed recommendations to standardize a hand hygiene program and has specific requirements of volume of observations per unit.

4. Outcomes:

- A multidisciplinary process improvement team has been developed to conduct a thorough review and identify opportunities for improvement.

- The background and current conditions have been evaluated and are tracked on an A3 document.
- The team has redeveloped the training program and is piloting this in January 2024.
- February, March, and April 2024 will be focused on training of Hand Hygiene champions and implementation of our audit program.
- Next steps include identifying unit champions and targeting the Leapfrog volume requirements for observations.

List of Attachments:

Attachment 1: Hand Hygiene A3 document

Works Cited

Lotfinejad N, P. A. (2021). Hand hygiene in healthcare: 20 years of ongoing advances and perspectives. *Lancet Infectious Disease*, 21:e209-21.

Title: Hand Hygiene Program **Sponsor(s): Holly Beeman, Lyn Garrett** **Process Owners: Catherine Nalesnik, Alyssa Santos, Stephelie Dumalag, Daniel Shin MD**

Team: Ann Aquino, Dee Shih, Julie Belisle, Jerry Kelly, Padmaja Vemula MD, Thai Vo MD, Linda Huynh MD Rev: 6 Date: 1/10/24

Background: What problem are we talking about and why?

Hand hygiene (H/H) is vital for the safety of our patients and staff. Audits of hand hygiene practice is necessary to track compliance as a mandatory element of Leapfrog reporting, as a requirement dictated by TJC, and as an integral part of our enterprise-wide H/H Program.

ECH's H/H Policy is based on the World Health Organization with compliance included in annual staff evaluations. We've had several past initiatives focused on H/H and a Gap analysis to WHO standards in 2002.

Problem Statement:

We do not have a robust hand hygiene program and are struggling to verify that H/H is happening. C.diff cases are on the rise which we suspect is partially due to gaps in H/H compliance.

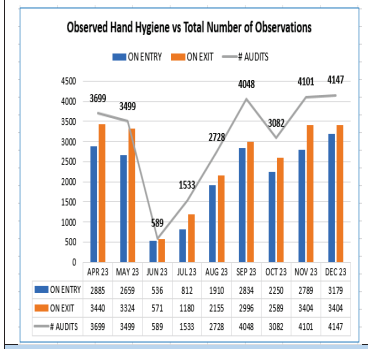
Current Conditions: Where do things stand now?

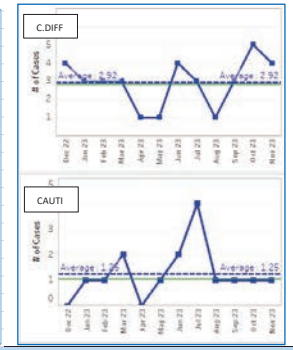
Hand hygiene audits indicate H/H is not consistently done. Audits themselves are completed inconsistently based on staff availability. Data is variable based on method of tracking and reporting.

Pre survey 'Known' reasons for noncompliance with H/H include inconsistent understanding of process, personal views or perceptions of the need to do handwashing, time and interruptions, and available resources. Real time coaching is not done due to discomfort in speaking up or calling someone out for not performing H/H.

Survey learnings: Staff didn't recognize "**germs already present on the patient**" as the most frequent source of germs responsible for HAIs.

Audit process observation learnings: Training for HH audit completion is variable, audits are not completed on nights or weekends.





Target Condition / Goal(s): What specific outcome is required, and by when?

Hand Hygiene Program: An enterprise-wide hand hygiene program that supports compliance through coaching/feedback with the goal of safety for patients & staff. The program should include mandatory training and demonstration of proper hand hygiene techniques for all healthcare workers with audits that satisfy Leapfrog reporting criteria.

Hand Hygiene compliance: hand hygiene internalized as a habit, "what we do" a cultural norm that is second nature resulting in an increase in hand hygiene compliance from current state and a positive correlation to HAC measures.

Gap Analysis: Why does the problem or need exist? Based on data, What are the Root Causes?

Top Contributors	Cause

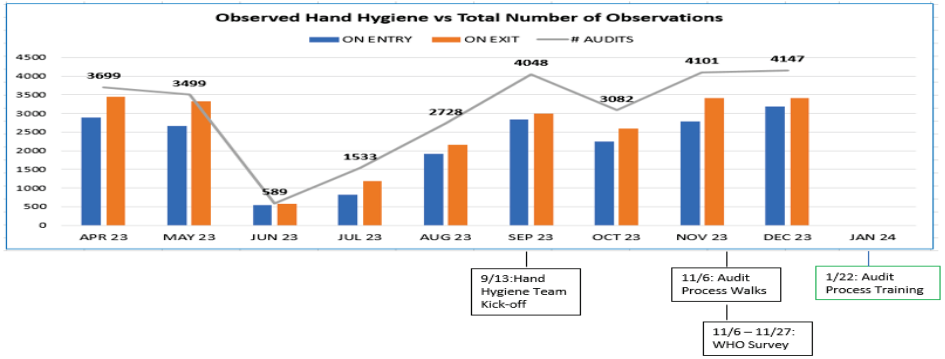
Audit process:

Inconsistent auditing process

- Variability in training
- Training is done by different people
- There is no agreed upon process or materials for training

Experiments: What do you propose and why?

Root Cause	Potential Countermeasure	Expected Impact
1. There is no agreed upon process or materials for training to do audits	Create a training program for auditing process	Consistent audit process that will give greater validation of hand hygiene compliance
2.		



Action Plan: How will you implement? 4Ws, 1H

RC 1. What	Why	Who	When	How
Auditing process training for transitional workers	To create a standard for training	Catherine N and a workgroup	Prep to be sent week of 11/27; work group meet 12/4	Use VA process as framework, make it our own
Train transitional workers with new process	Create consistency and rigor in the process	Catherine and workgroup with Education Dept	January 22, 2024	HealthStream and videos
Pilot Audit process and training with transitional workers Gather data for PDSA	Focused pilot will allow for PDSA of process/training	Catherine and workgroup	Mid-January through Mid-February	Use survey to gather data on process & edit. Identify unit champions for implementation
Implement /spread Audit process throughout	Standardized process needed for accurate compliance data	Catherine and workgroup with Education Dept	Mid-February	Department Champions

Study, Reflect, Plan Next Steps: How will you assure ongoing PDSA?

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
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Date: February 5, 2024
Subject: Hand Hygiene Process Improvement

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on the Hand Hygiene Process Improvement activities.

Recommendation:

Informational only.

Summary: Hand Hygiene is the number one tool to reduce hospital acquired infections. ECH wants to evaluate and update our Hand Hygiene program to optimize our auditing process to ensure and improve compliance with hand hygiene.

1. Situation: ECH Hand Hygiene program needs to be evaluated and redesigned to achieve a sustained improvement in hand hygiene compliance.

2. Background: Hand hygiene is vital for the safety of our patients and staff. Audits of hand hygiene practice is necessary to track compliance as a mandatory element of Leapfrog reporting, as a requirement dictated by TJC, and as an integral part of our enterprise-wide hand hygiene program.

We've had several past initiatives focused on hand hygiene, most recently in FY23. Prior initiatives have improved compliance, but only for a limited time (2-3 months). This is similar to the experience of other health systems. Medical literature is rife with publications demonstrating a short-lived improvement in hand hygiene following an enterprise-wide campaign. The average hand hygiene compliance rate has been reported as 40% in high-income countries like the United States. (Lotfinejad N, 2021)

Problem Statement:
We do not have a robust hand hygiene program and have inconsistent practices of performing hand hygiene audits, and poor hand hygiene compliance based on the limited number of audits performed. Having hospital acquired C.diff infections in low risk patients who are in proximity to patients in isolation who are colonized with C. Diff suggests our hand hygiene compliance is not optimal.

3. Assessment: ECH has an opportunity to improve the Hand Hygiene program (auditing and compliance), Leapfrog has developed recommendations to standardize a hand hygiene program and has specific requirements of volume of observations per unit.

4. Outcomes:

- A multidisciplinary process improvement team has been developed to conduct a thorough review and identify opportunities for improvement.

- The background and current conditions have been evaluated and are tracked on an A3 document.
- The team has redeveloped the training program and is piloting this in January 2024.
- February, March, and April 2024 will be focused on training of Hand Hygiene champions and implementation of our audit program.
- Next steps include identifying unit champions and targeting the Leapfrog volume requirements for observations.

List of Attachments:

Attachment 1: Hand Hygiene A3 document

Works Cited

Lotfinejad N, P. A. (2021). Hand hygiene in healthcare: 20 years of ongoing advances and perspectives. *Lancet Infectious Disease*, 21:e209-21.

Title: Hand Hygiene Program **Sponsor(s): Holly Beeman, Lyn Garrett** **Process Owners: Catherine Nalesnik, Alyssa Santos, Stephelie Dumalag, Daniel Shin MD**

Team: Ann Aquino, Dee Shih, Julie Belisle, Jerry Kelly, Padmaja Vemula MD, Thai Vo MD, Linda Huynh MD Rev: 6 Date: 1/10/24

Background: What problem are we talking about and why?

Hand hygiene (H/H) is vital for the safety of our patients and staff. Audits of hand hygiene practice is necessary to track compliance as a mandatory element of Leapfrog reporting, as a requirement dictated by TJC, and as an integral part of our enterprise-wide H/H Program.

ECH's H/H Policy is based on the World Health Organization with compliance included in annual staff evaluations. We've had several past initiatives focused on H/H and a Gap analysis to WHO standards in 2002.

Problem Statement:

We do not have a robust hand hygiene program and are struggling to verify that H/H is happening. C.diff cases are on the rise which we suspect is partially due to gaps in H/H compliance.

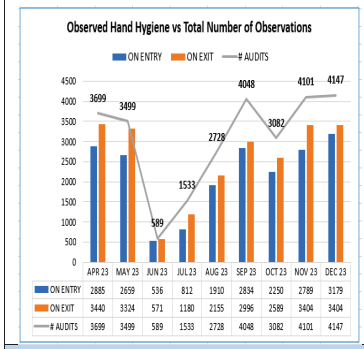
Current Conditions: Where do things stand now?

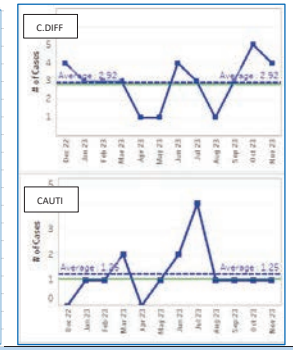
Hand hygiene audits indicate H/H is not consistently done. Audits themselves are completed inconsistently based on staff availability. Data is variable based on method of tracking and reporting.

Pre survey 'Known' reasons for noncompliance with H/H include inconsistent understanding of process, personal views or perceptions of the need to do handwashing, time and interruptions, and available resources. Real time coaching is not done due to discomfort in speaking up or calling someone out for not performing H/H.

Survey learnings: Staff didn't recognize "**germs already present on the patient**" as the most frequent source of germs responsible for HAIs.

Audit process observation learnings: Training for HH audit completion is variable, audits are not completed on nights or weekends.





Target Condition / Goal(s): What specific outcome is required, and by when?

Hand Hygiene Program: An enterprise-wide hand hygiene program that supports compliance through coaching/feedback with the goal of safety for patients & staff. The program should include mandatory training and demonstration of proper hand hygiene techniques for all healthcare workers with audits that satisfy Leapfrog reporting criteria.

Hand Hygiene compliance: hand hygiene internalized as a habit, "what we do" a cultural norm that is second nature resulting in an increase in hand hygiene compliance from current state and a positive correlation to HAC measures.

Gap Analysis: Why does the problem or need exist? Based on data, What are the Root Causes?

Top Contributors	Cause

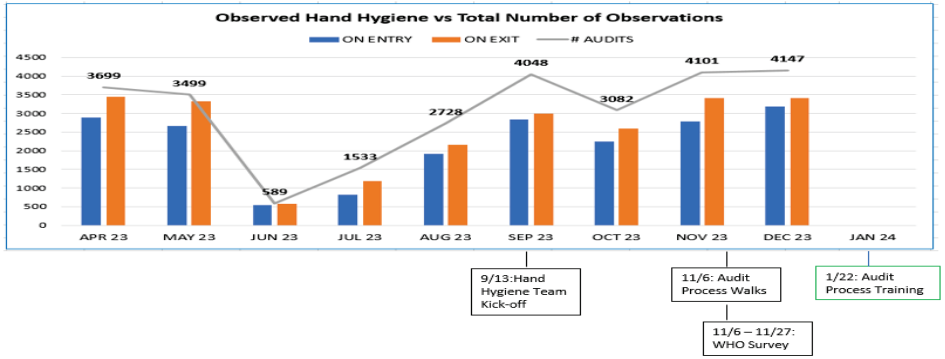
Audit process:

Inconsistent auditing process

- Variability in training
- Training is done by different people
- There is no agreed upon process or materials for training

Experiments: What do you propose and why?

Root Cause	Potential Countermeasure	Expected Impact
1. There is no agreed upon process or materials for training to do audits	Create a training program for auditing process	Consistent audit process that will give greater validation of hand hygiene compliance
2.		



Action Plan: How will you implement? 4Ws, 1H

RC 1. What	Why	Who	When	How
Auditing process training for transitional workers	To create a standard for training	Catherine N and a workgroup	Prep to be sent week of 11/27; work group meet 12/4	Use VA process as framework, make it our own
Train transitional workers with new process	Create consistency and rigor in the process	Catherine and workgroup with Education Dept	January 22, 2024	HealthStream and videos
Pilot Audit process and training with transitional workers Gather data for PDSA	Focused pilot will allow for PDSA of process/training	Catherine and workgroup	Mid-January through Mid-February	Use survey to gather data on process & edit. Identify unit champions for implementation
Implement /spread Audit process throughout	Standardized process needed for accurate compliance data	Catherine and workgroup with Education Dept	Mid-February	Department Champions

Study, Reflect, Plan Next Steps: How will you assure ongoing PDSA?

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, DiplACLM
Date: February 5, 2024
Subject: Patient Voice/Press Ganey Comment

Purpose:

To provide the Committee with written patient feedback that is received via a Press Ganey comment through the patient experience survey process.

Summary:

1. Situation: This comment is from our Press Ganey patient comment portal from a patient in our MV labor and delivery (L&D) unit on January 19th and our Maternity unit on November 7th. The comments are mostly positive but indicate that there is indeed a need to update our L&D unit and more education is needed on how to use the lights.

2. Background: This comment was written by the patient who wanted to express positive feedback about the care, but who felt the old unit and construction noise of the L&D unit resulted in a more difficult experience. In addition, the second comment indicates that more education is needed regarding lights in the new Maternity unit.

3. Assessment: These comments indicate that our older L&D units need a refresh as is happening right now—one room at a time. However, the EVS staff have done an excellent job in keeping the unit clean. The new area on 3rd floor that is Maternity is well received with the exception of needing to ensure all areas of the room are integrated in the orientation to the room for our families.

4. Outcomes: We currently are in the process of remodeling and expanding our L&D unit at MV. In addition, we have 'noise' kits that we distribute to all patients (ear plugs, eye mask, etc.) to help mitigate the construction noise. We also work closely with the construction crew to minimize noise during critical times throughout the day. This also allows us to communicate with families so they are prepared for the noises they may be hearing. We will coach our staff to make sure that all patients receive instruction on how to use the lights. We are partnering with EVS to ensure that all rooms are clean.

5. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. How do you recognize and determine the resources and priorities for those items that are brought forward by patients?

2. How else do we receive feedback from patients who deliver here during construction and make changes based on their feedback?

Patient Voice/Press Ganey Comment
February 5, 2024

Patient Comment: Press Ganey 1/19/2024

“Labor and Delivery Room was clean but out of date. The construction noise was awful and made the experience of labor that much harder”.

Patient Comment: Press Ganey 11/7/23

“New wing for L&D was lovely. The bed, both couch/bed were better than expected. Some directions on how to use the lights could have been helpful”

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, and Chief Quality Officer
Date: February 5, 2024
Subject: Enterprise Quality, Safety and Experience and STEEEP Dashboards through December 2023

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety, and experience measure performance through December 2023 (unless otherwise noted). This memo will describe performance from both the STEEEP and Enterprise Quality Dashboards.

Situation:

The FY 23 Enterprise Quality, Safety and Experience Dashboard is updated monthly and tracks nineteen quality measures. The STEEEP dashboard is updated each quarter and contains twenty measures. The STEEEP dashboard is intended to be a Governance Level report, which is shared with the El Camino Hospital Board of Directors on behalf of the Quality Committee once a quarter. Most measures are tracked on both the Enterprise monthly and STEEEP quarterly dashboards.

A. Safe Care

Hospital Acquired Condition Index 2.0

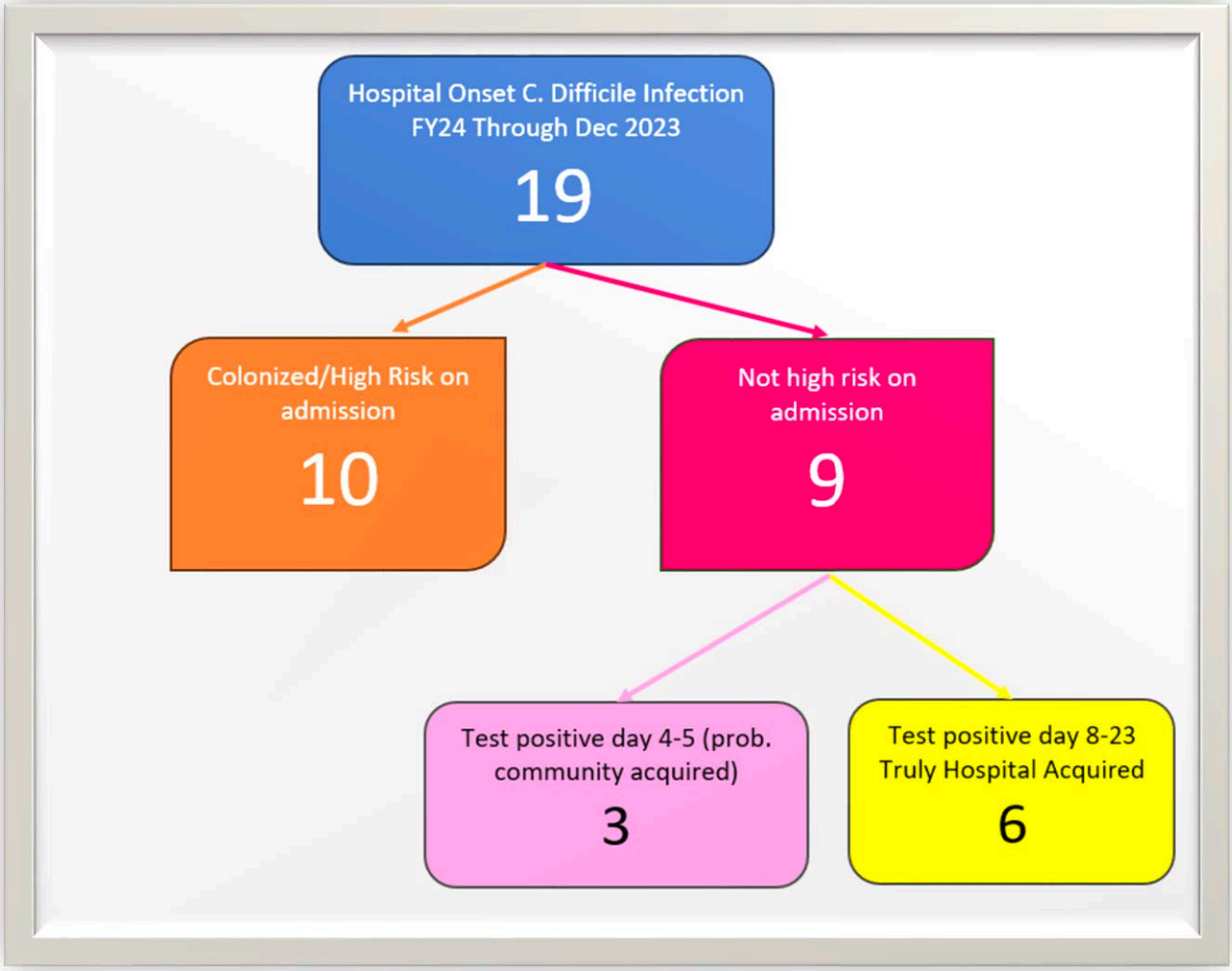
This measure is a composite of four measures as illustrated below.

FY 24 HAC 2.0 weighting and targets			
Component	**Denominator**	**Weighting**	**Weighted Rate**
CLABSI	per 1,000 central line days	25%	aa
CAUTI	per 1,000 catheter days	25%	bb
C. Diff	per patient days x 10,000	25%	cc
nvHAP	per patient days x 1,000	25%	dd
		SUM	HAC Index

1. HAC Index 2.0 is the strategic quality and safety goal for FY24. For the month of December (1.284) and Fiscal Year-To-Date (1.300) we are unfavorable to target of (1.201)

    1.1. **C. Difficile Infection:** The C. Diff rate per patient days x 10,000 (1.112) for the second quarter and year to date (0.880) are unfavorable to target (0.805). There have been 19 hospital acquired infections in FY24. Of these 19 C. Difficile infections, six were likely

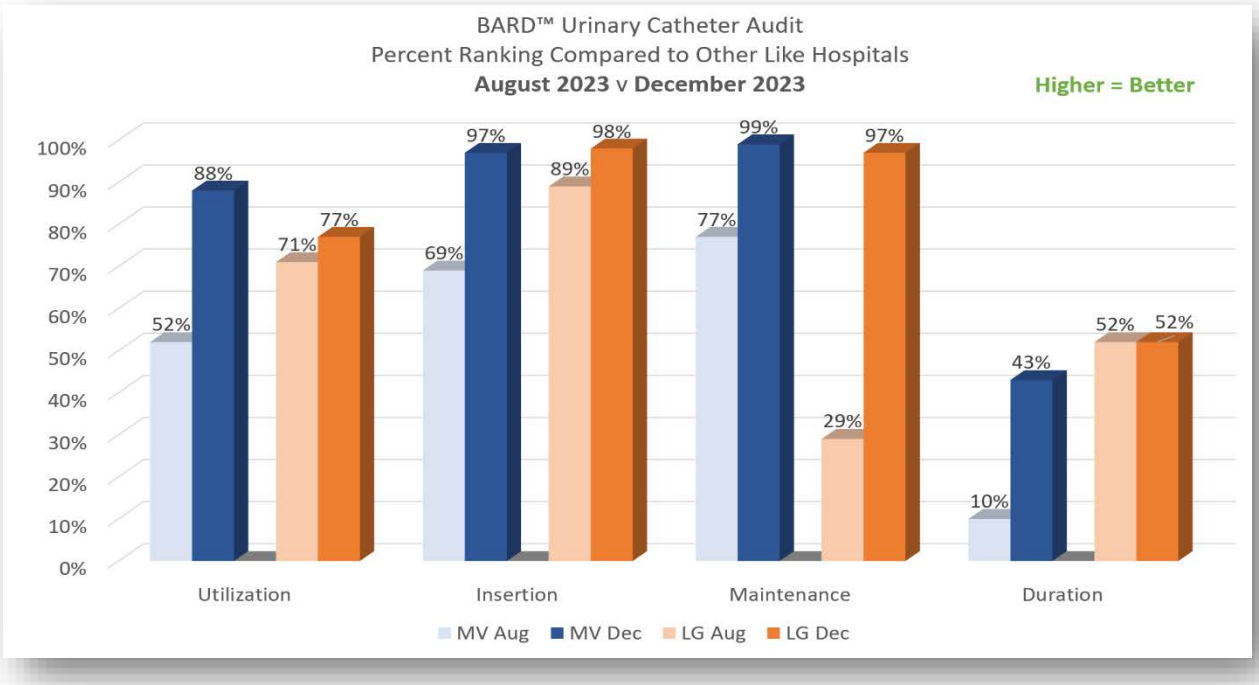
preventable. Areas of focus to decrease C. Diff are twofold. First, hospital wide



education on C. Diff screening, testing and prevention. (See attachment: CdiffHAC2-24 Education Flyer) Second, deployment of enterprise-wide hand hygiene program. A detailed report describing the hand hygiene process improvement initiative is included in the consent agenda portion of the packet as a Quality Committee follow up item.

1.2. **Catheter Associated Urinary Tract Infection (CAUTI):** The rate of catheter associated urinary tract infection per catheter days for Q2 (0.192) is significantly improved from Q1 (0.356) and is approaching target (0.166). As of January 29, 2024, it has been 56 days since the last CAUTI in Mountain View and 176 days since the last CAUTI in Los Gatos. There have been nine CAUTI year to date with a goal to have less than twelve for the fiscal year. There were four infections in July, and one per month in August through December 2023. Eight of the nine patients with CAUTI were profoundly ill and unstable resulting in an ICU stay and close fluid management via prolonged utilization of a urinary catheter (> 3 days). Having too much or too little intravascular fluid can result in catastrophic damage to the lungs, kidneys, and heart. Close fluid management involves meticulous measurement of fluids going in and fluid

going out (urine). The most accurate way to monitor urine output to be accurate to the milliliter is via an indwelling urinary catheter.
Process improvement foci to reduce CAUTI are 1. Remove catheters as soon as possible when clinically appropriate, and 2. Ensure insertion and maintenance best practices are followed. To achieve shorter catheter duration, our infection prevention team rounds on every single patient with a catheter in for greater than three days and collaborates with the nurse and physician to review indications for the catheter and direct attention to the importance of removing the catheter as soon as clinically appropriate. This intervention is likely contributing the improved performance in the second quarter of FY24. Optimizing catheter insertion and maintenance performance has been achieved through partnership amongst our Infection Prevention team, unit champions and BARD™, the vendor who provides our catheters. We requested an independent audit from BARD™ of our catheter practices in August 2023 with a re-visit and audit in December 2023. There has been significant improvement in the 4-month interval between audits. The results are depicted in the bar graph below which illustrates our percentile ranking compared to other like hospitals in catheter best practices. You will appreciate that the domain of catheter duration is where we continue to have the greatest opportunity. This informs our focus on removing catheters timely when clinically appropriate. "When in doubt, take it out!"



1.3. **Central Line Associated Blood Stream Infection (CLABSI)**. The rate of CLABSI for second quarter (0.075) and year to date (0.039) are favorable to target (0.150). There has been one CLABSI year to date. This time in FY23 there were seven CLABSIs. The isolated CLABSI was in a NICU patient whose mother was colonized during pregnancy with the same organism which grew in the central line. This suggest the neonate was colonized at birth and this was likely not a hospital acquired infection. Per CDC guidelines, however, we count it this as a CLABSI. Our focus, to sustain our favorable

CLABSI performance, is on optimizing care and management hemodyalsis catheters. In FY23 the majority of CLABSIs were related to hemodyalsis catheters.

1.4. **Non-ventilator Hospital-Acquired Pneumonia (nvHAP).** The FY24 Q2 nvHAP rate (0.081) improved from Q1 (0.125) and is approaching target (0.080). Two interventions, mobilizing our patients out of bed, and having regular oral care are in place. Both practices are contributing to the successful decrease in nvHAP infections affecting our patients.

2. **Surgical Site Infection**. The rate of surgical site infections for FY23 Q2 (0.31) is favorable to target (0.369). There have been no total knee replacement (TKR) infections in FY24. As of January 29, 2024, it has been 294 days since the last TKR infection in Los Gatos and 271 days in Mountain View. Process improvement has included staff education on hand hygiene, surgical attire, and sterile equipment processing. These initiatives have decreased surgical site infections for TKR surgeries. The OR departments are continuing their work on vendor behavior and reducing traffic and door opening during orthopedic joint replacement surgical procedures.

B. Timely

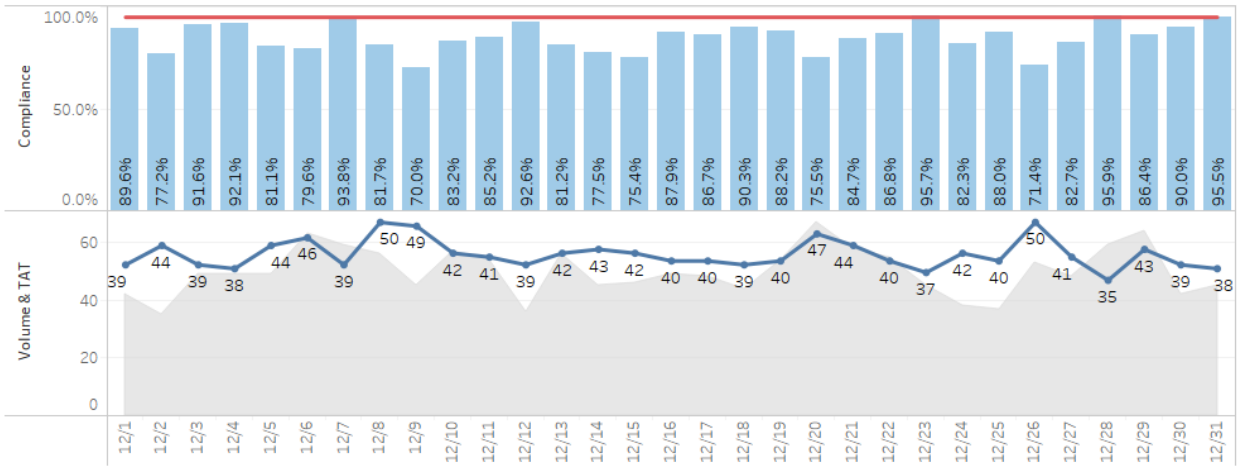
1. **Lab STAT Troponin Turnaround Time for Emergency Department (received to verification).** [1]The goal is to have 90% of results back within (40 minutes). Performance in Q2 FY24 (81.3%) is unfavorable to target. Below is a detailed analysis of gaps and corrective actions to improve our performance.

What is affecting our TAT?		
Item	**Description**	**Corrective Action**
DxI Downtime (Analytical Instrument Running Troponin Test x2) **OR** **DxA Downtime (Chemistry line processing the specimens for testing on the DxI)**	We continue to experience downtimes for our DxI & DxA instrumentation. Increase in TAT may be seen when at least 1 instrument is down or if the line is down/partial down. Details of errors can be sent on request.	Continue to monitor downtimes and escalate to vendor ones that we frequently see.
High Troponin Values	Troponin values above a certain threshold is at risk for cross-contamination between subsequent specimens tested.	The manufacturer is aware of this limitation, and we have escalated for a resolution multiple time.

[1] A troponin test measures the levels of troponin proteins in the blood. These proteins are released when the heart muscle has been damaged, such as occurs with a heart attack. The more damage there is to the heart, the greater the amount of troponin there will be in the blood. Outcomes of patients experiencing a heart attack (myocardial infarction) in the ED improve when interventions occur timely. Having the results of troponin blood test within 40 minutes to inform care team of the patient's cardiac status enables timely intervention.

	When identifying a high troponin value, we are required to remove the reagent from the instrument and perform maintenance to eliminate cross-contamination risks. This takes time to perform.	Currently no update on their end for a resolution.
Maintenance	Maintenance of the DxI or DxA will require periodic downtimes. The time for maintenance may be increased due workload as the staff have to juggle both maintenance and releasing of patient results. Delays can be exacerbated with staffing shortages.	Beckman Coulter to help identify process improvement opportunities in the next month.
Critical Calls	Critical calls affect our TAT as we release the result to the patient only after we make the phone call to the care team. Depending on the capacity for the unit to quickly answer the call, this will delay our release times (affecting this metric).	Now, we are calling a large number of troponin results. We are working with the cardiovascular service line to adjust the critical call threshold.

Daily metric for Troponin TAT for December 2023



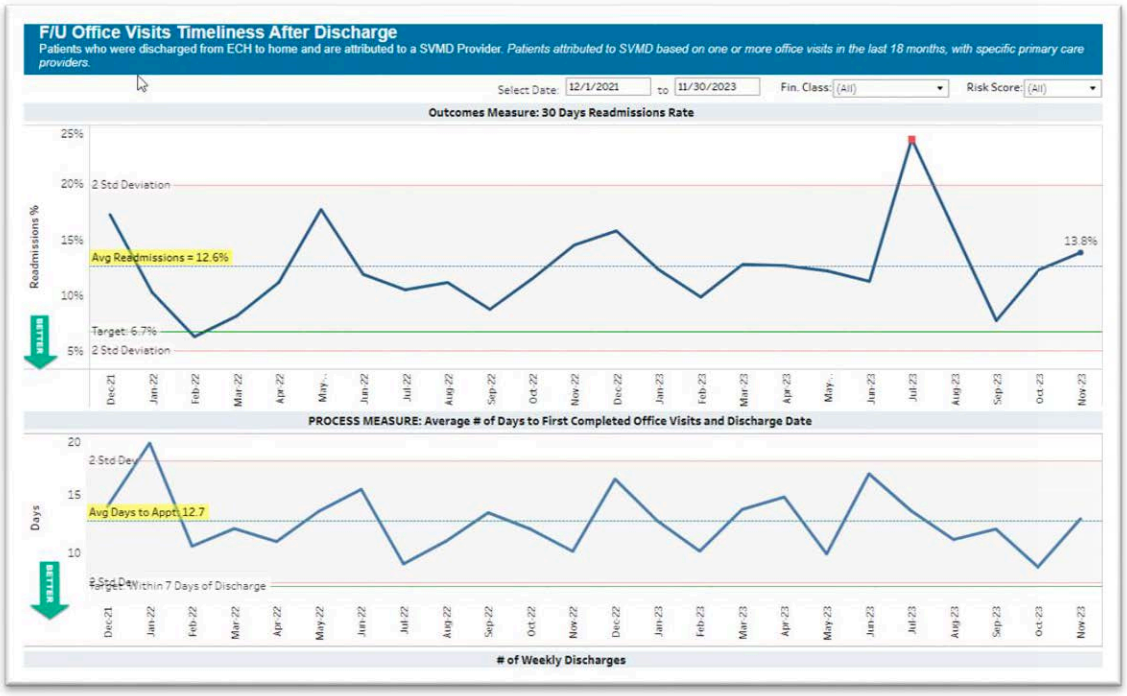
2. Imaging Turnaround Time: ED including X Ray (target + % completed <= 45 minutes). Performance for Q2 (76.5%) and YTD (76.4%) are unfavorable to target (84%). Root cause of the delays relates to the suboptimal performance of the 'night hawk' radiology vendor who performs readings for the hospitals after hours. A transition to the new nighttime partner will take effect February 13, 2024. Within 3-months of this transition, we anticipate a significant improvement (decrease) in reading times.

C. Effective

1. Risk Adjusted Readmission Index. Performance through November YTD (1.13) is unfavorable to target (1.0). Having timely follow-up with a clinician within 14 days of discharge decreases readmissions. A recent publication demonstrated a 42% decreased risk of being readmitted within 30 days of discharge for those patients seen in a post discharge clinic within 14 days of discharge. (Michael Baldino D.O., April 2021)

> *Avoidable 30-day readmissions cost the Center for Medicare and Medicaid Services (CMS) $17 billion per year.[1] As a result, the Hospital Readmission Reduction Program (HRRP) was enacted in 2012 as a part of the Patient Protection Affordable Care Act.[2] This directive set penalties for hospitals with excess readmissions for diagnoses commonly associated with adverse events. (Michael Baldino D.O., April 2021)*

El Camino Health teams are focused on ensuring patients who have an SVMD primary care provider have timely follow up post discharge. The readmission rates for these patients tracks closely with their ability to be seen timely after discharge. See screenshot below “F/U Office Visits Timeliness After Discharge” from the tableau dashboard created by Steven Sun (Director Clinical Data Analytics) and his team. The top chart shows readmission rates for SVMD patients following hospitalization at ECH. The bottom chart shows the average number of days between discharge and follow up appointment with SVMD primary care physician. Animating the benefits for our patients of being an enterprise, the ECH ambulatory and inpatient teams are collaborating to optimize navigation and integration of care between the hospital and clinic setting.



2. Risk Adjusted Mortality Index. Performance for FY24Q2 (1.13) and YTD (1.07) are unfavorable to target (1.00). Mortality index tracks, and for this time frame, is driven by the sepsis mortality.

3. Sepsis Mortality Index. Performance for FY24Q2 (1.32) and YTD (1.20) is unfavorable to target (1.0). You may recall from the focused review on sepsis shared with you in November 2023, that compliance with the 7 elements of the sepsis bundle correlates strongly with patient outcomes. Bundle compliance for both campuses remains excellent through FY23Q2. Every single sepsis mortality is reviewed. Reviews from the past quarter highlight that patients are being transferred from SNFs to ECH to die with end stage complications of disease and sepsis. There is no change in care or attention to bundle compliance which would have prevented these end-of-life patients from expiring. To provide better care to end-of-life patients and their families we are looking forward to the re-establishment of a comprehensive inpatient hospice program (GIP—General Inpatient Care) now that our new Medical Director of Palliative care joined the organization in November 2023. If a terminal patient presents at the end of life, and we have the capability of caring for the patient and their family in an inpatient hospice setting, the support for the patient, and the impact on our mortality measurement is favorable. Patients admitted to GIP are no longer counted in the mortality tracking. We are doing an excellent job of caring for patients with sepsis. We have an opportunity to improve the support we provide to patients and their families at the end of life through a robust GIP program.

4. PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV). Since assuming the inaugural role of Chief Quality Officer for ECH in November 2021, this is the first time I have born witness to a cesarean section rate of 23.2% for nulliparous women having a singleton vertex pregnancy! The FY24Q2 performance (23.2%) is favorable to target of 23.9%. The maternal child health service line is a leader in recognizing and addressing the cultural norms

and expectations of our patients in how they view, engage with and approach health care. Greater than 63% of patients who deliver at ECH are Asian. In our experience, South Asian patients have a low tolerance for the uncertainties, risks, and pain involved with a vaginal delivery and low threshold for requesting a cesarean section. The MCH team, in recognition of the preferences and perspectives of our South Asian maternity patients, has created a culturally sensitive and clinically appropriate pre-natal childbirth education program for S. Asian expectant families. Please see attachment 4, *Health Pregnancy for South Asian Families*.

D. Efficient

1. **Length of Stay O/E (LOS O/E).** Length of stay is a measure of operational efficiency. The quality of care a patient receives is reliant on the navigation, coloration and efficiency achieved through operational excellence. Having timely, coordinated, and appropriate care has a profound impact on the overall quality of care our patients receive. Performance YTD (1.20) is unfavorable to target (1.15). A formidable challenge to decreasing length of stay for patients whose discharge disposition is a skilled nursing facility (SNF) are the barriers payors have in place to authorize timely discharge to a SNF. Our teams our optimizing care coordination within our system to decrease length of stay. Here are specific interventions in place:
    - We have created a centralized care plan in Epic that pulls together important information about the patients care plan. Information includes the medical care plan for the day, rehab recommendations, discharge destination, social drivers of health, and estimated date of discharge. This tool allows the care team to obtain pertinent information in a timely way without having to dig through the chart. Additionally, we are tracking delays to obtain more insight into the primary reasons for delays in patient throughput.

    - Multidisciplinary rounds (MDR) have been activated on 2C, and they continue in Los Gatos. Both teams have incorporated use of the centralized care plan in MDR. At the 30-day check-in we have seen a significant LOS decrease of **-0.5 days** on 2C for the pilot population.

    - We now have 3 skilled nursing facility transfer agreements in place (Cedar Crest, Grant Cuesta and Mountain View Health Care). These agreements help us expedite discharge to SNF for the self-pay and MediCal patients. We transfer about 3-4 patients per month utilizing the transfer agreements and are working to increase utilization of the transfer agreements.

    - The discharge lounge continues to be open Monday-Friday and nursing and case management work together to identify appropriate patients who can discharge to the lounge to help expedite discharges and increase bed capacity.

2. **Median Time from ED Arrival to ED Departure (Enterprise).** The current FY24Q2 performance (154 minutes) and YTD (156 minutes) is favorable to the target of 165 minutes (lower is better). This performance is years in the making with an overhaul of the patient triage process, creation of additional chairs for less acute patients, and, most recently the creation of an ED express area on the Mountain View Campus. The ED express has capacity for 6 patients of lower acuity and will allow our teams to provide more efficient care for patients of lower acuity (treat to street).

E. Equitable

1. **Homeless discharge documentation of providing appropriate clothes.** In Q2 of FY24 documentation of offering weather appropriate clothing to homeless patients prior to discharge has improved from 53% to 69%. The health equity department is partnering with nursing clinical documentation team to reduce the inefficiencies in our EMR build which obfuscate consistent documentation of compliance with our homeless discharge policy.

2. **Quality Council Health Equity Item Included in Process Improvement Efforts (% of departments).** With the return of our Health Equity manager from a medical leave, the health equity team has been able to coach and support departments to include at least one improvement measure viewed through an equity lens. For the second quarter of FY2024 four of twelve departments reported on a health equity measure during their annual performance improvement report at the monthly Quality Council meeting.

3. **Sepsis Bundle Compliance by Race.** We continue to track and learn from segregating some of our quality measures by race, whilst optimizing the accuracy of race data we collect from our patients at the time of registration. The quality of 'race' data provided by our patients must improve prior to deducting meaningful information about sepsis bundle compliance by race. That said, as we continue to track this measure, the increase in the denominator over time will render the measures more meaningful.

F. Other Measures

Patient Experience Measures. Performance in patient experience is favorable to target in our Emergency Department, Maternal Child Health, and Inpatient Units. We continue to exceed our target for our Likelihood to Recommend (LTR) scores across the enterprise due to our continued commitment and focus on our evidence-based best practices. This includes hourly (purposeful) rounding, leader rounding, bedside shift report and enhanced communication using our WeCare practices.

Attachments:

1. Enterprise Quality Dashboard through December 2023
2. STEEEP Dashboard through Q2 of FY2024
3. CdiffHAC2-24 Education Flyer
4. Health Pregnancy for South Asian Families Flyer

Works Cited

Advisory Board. (2022, May). *The State of the Post-Acute Workforce.* Advisory.com.

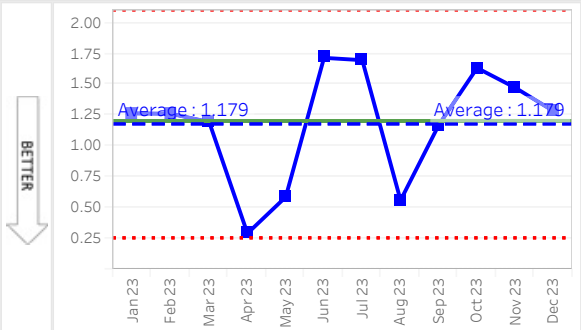
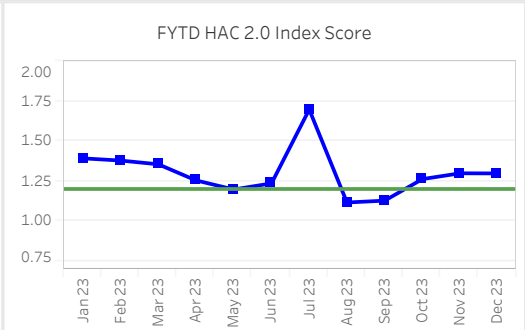
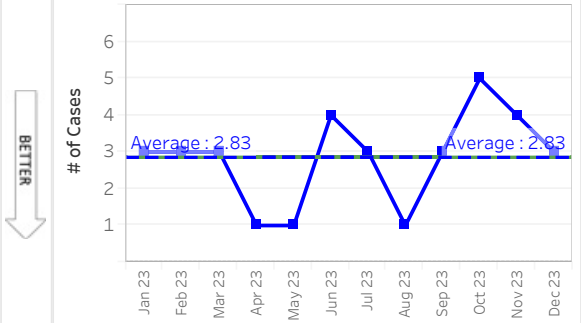
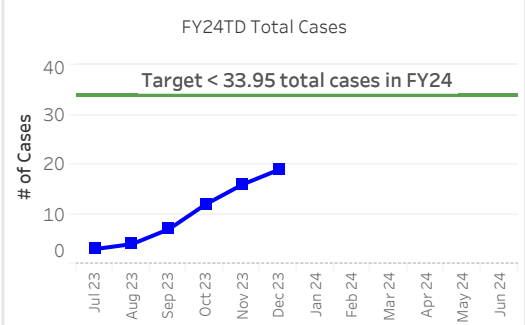
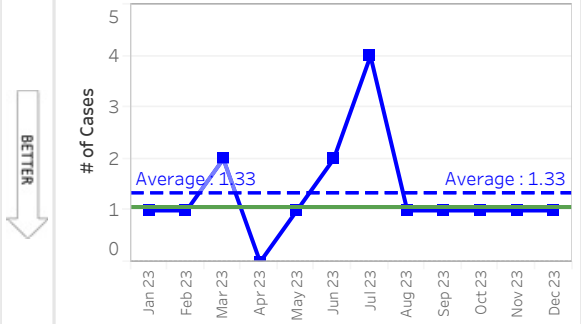
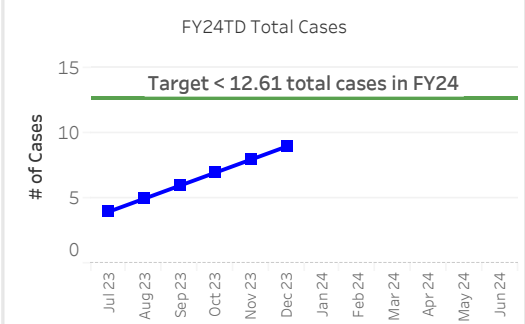
Michael Baldino D.O., M. a. (April 2021). Impact of a Novel Post-Discharge Transitions of Care Clinic on Hospital Readmissions. *Journal of the National Medical Association*, Pages 133-141.

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

December 2023 (unless other specified)

Month to Board Quality Committee : February 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal HAC Index 2.0 Latest Month : December 2023	1.284	1.300	1.238	1.201 (3.0% ↓)		
HAC Component Clostridium Difficile Infections (C-Diff) Latest Month : December 2023	3 cases	3.17 cases/mo	2.92 cases/mo	2.83 cases/mo		
HAC Component Catheter Associated Urinary Tract Infection (CAUTI) Latest Month : December 2023	1 cases	1.50 cases/mo	1.08 cases/mo	1.05 cases/mo		

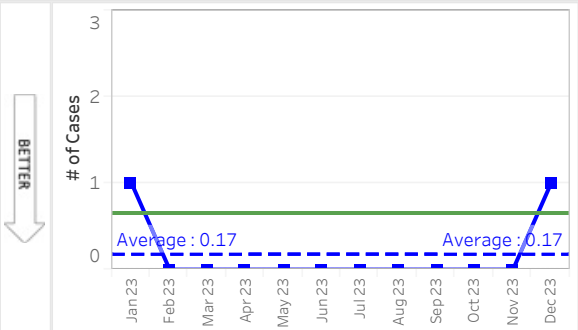
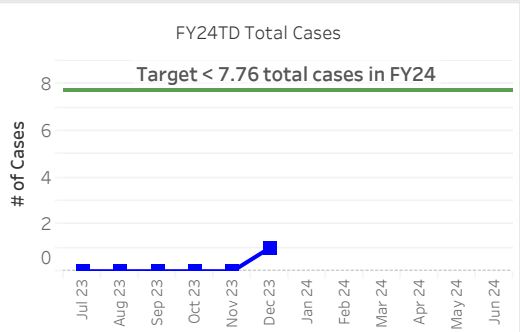
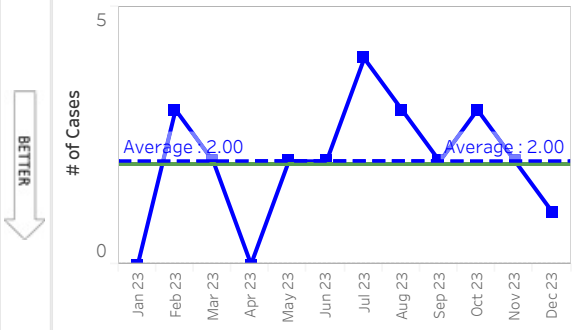
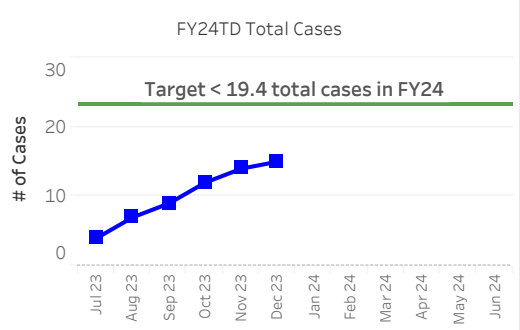
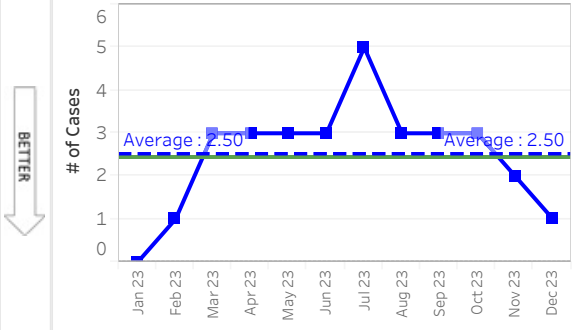
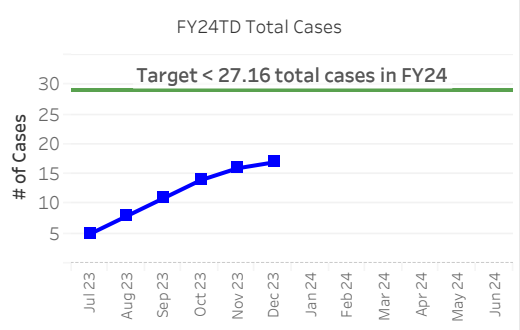
Quality Department | Note : updated as of January 23, 2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

December 2023 (unless other specified)

Month to Board Quality Committee : February 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
HAC Component Central Line Associated Blood Stream Infection (CLABSI) Latest Month : December 2023	1 cases	0.17 cases/mo	0.67 cases/mo	0.65 cases/mo		
HAC Component non-ventilator Hospital-Acquired Pneumonia (nvHAP) Latest Month : December 2023	1 cases	2.50 cases/mo	2.00 cases/mo	1.94 cases/mo		
Surgical Site Infections (SSI) Latest Month : December 2023	1 cases	2.83 cases/mo	2.50 cases/mo	2.42 cases/mo		

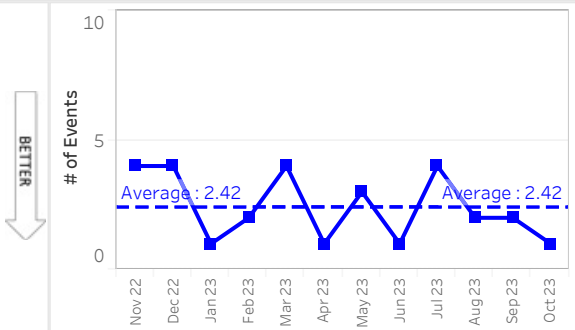
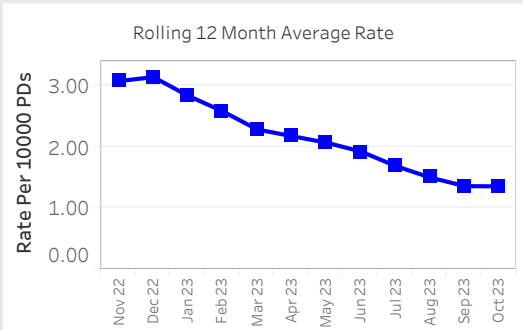
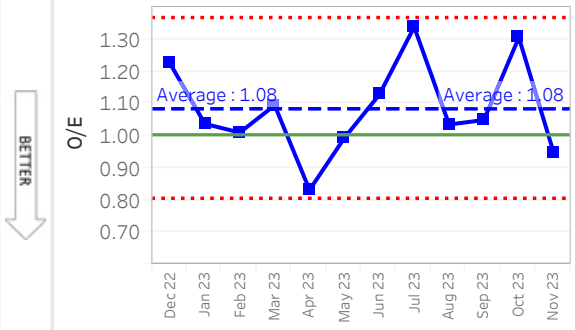
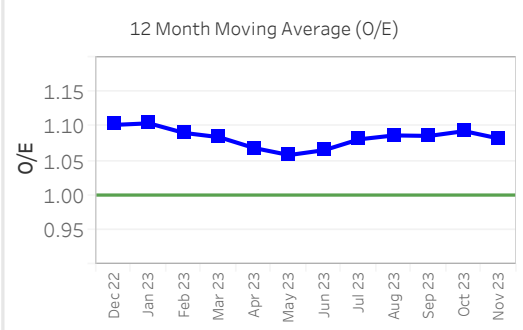
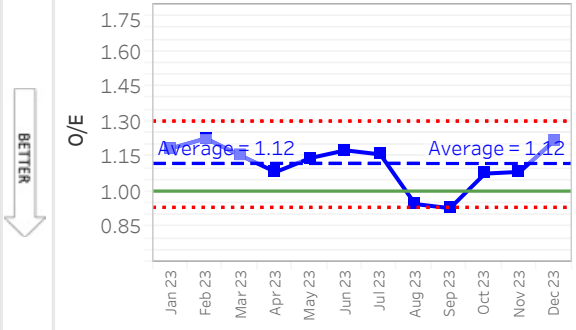
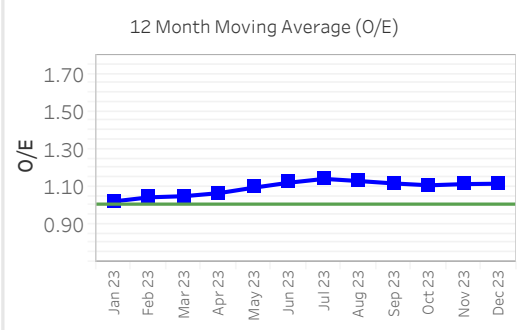
Quality Department | Note : updated as of January 23, 2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

December 2023 (unless other specified)

Month to Board Quality Committee : January 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Serious Safety Event Rate (SSER) Latest Month : October 2023	1 events	1.26 (9 / 71355)	1.93 (41 / 212460)	n/a		
Readmission Index (All Patient All Cause Readmit) Observed / Expected Premier Care Sciences Standard RA Latest Month : November 2023	0.95 (7.17% / 7.58%)	1.13 (9.02% / 7.95%)	1.07 (8.47% / 7.94%)	1.00		
Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : December 2023	1.22 (2.78% / 2.28%)	1.07 (2.04% / 1.91%)	1.13 (2.21% / 1.96%)	1.00		

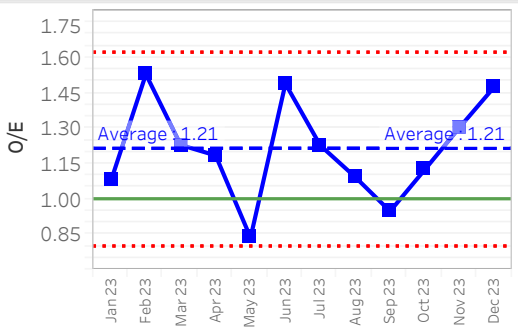
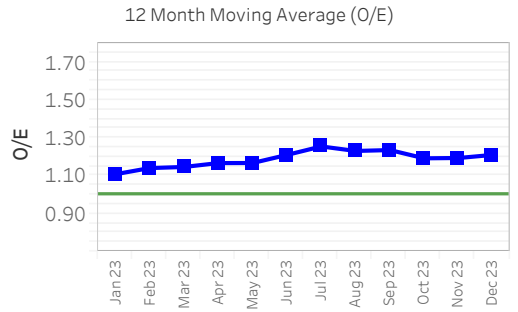
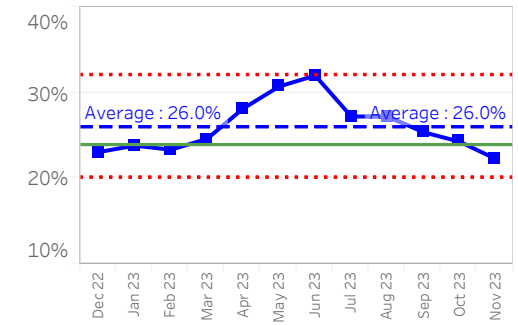
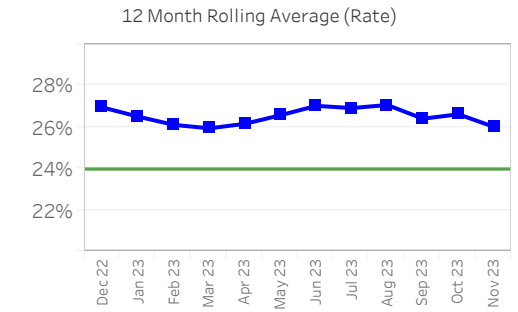
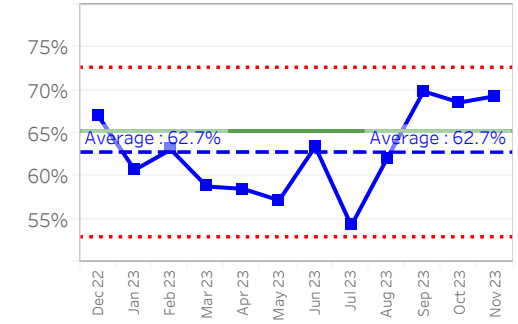
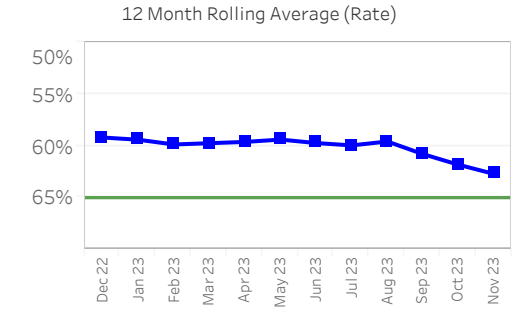
Quality Department | Note : updated as of January 23, 2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

December 2023 (unless other specified)

Month to Board Quality Committee : February 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Sepsis Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : December 2023	1.48 (18.13% / 12.26%)	1.20 (13.73% / 11.44%)	1.21 (14.07% / 11.59%)	1.00		
PC-02 : Cesarean Birth Latest Month : November 2023	MV : 21.9% (40 / 183) LG : 25.0% (7 / 28) ENT : 22.3% (47 / 211)	MV : 26.3% (222 / 845) LG : 17.8% (21 / 118) ENT : 25.2% (243 / 963)	MV : 28.1% (530 / 1883) LG : 20.1% (65 / 323) ENT : 27.0% (595 / 2206)	23.9% (FY24 ENT Target)		
PC-05 : Exclusive Breast Milk Feeding Latest Month : November 2023	MV : 67.7% (210 / 310) LG : 82.1% (32 / 39) ENT : 69.3% (242 / 349)	MV : 66.7% (1023 / 1534) LG : 83.6% (183 / 219) ENT : 65.0% (1127 / 1734)	MV : 58.1% (1966 / 3385) LG : 68.3% (427 / 625) ENT : 59.7% (2393 / 4010)	65.1% (FY24 ENT & MV Target) 70.0% (FY24 LG Target)		

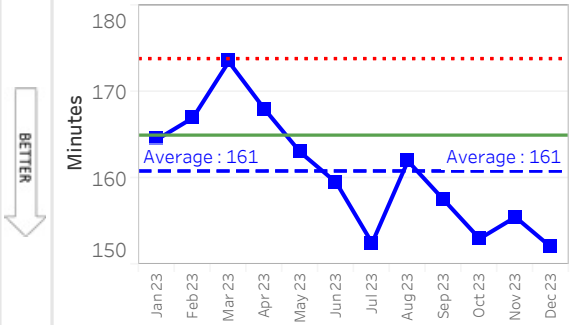
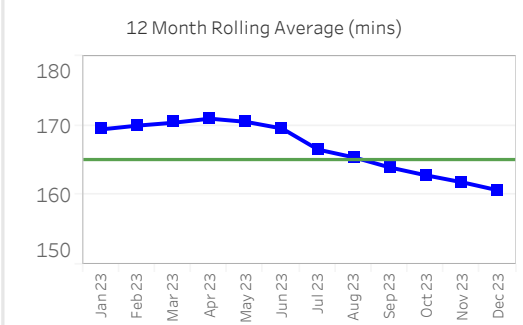
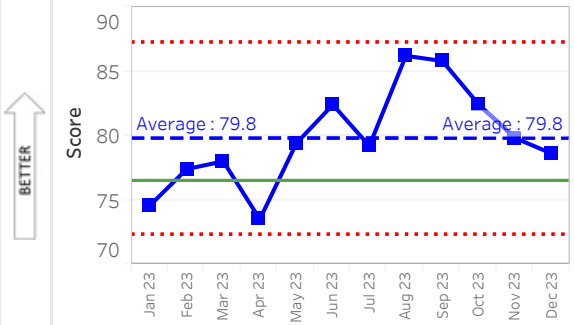
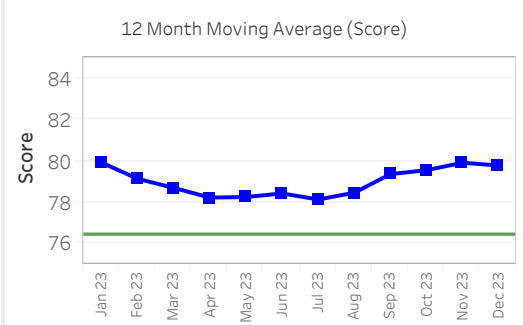
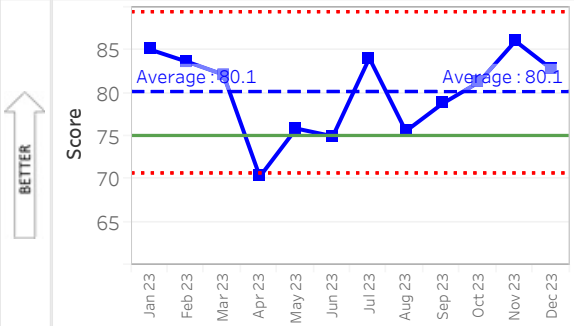
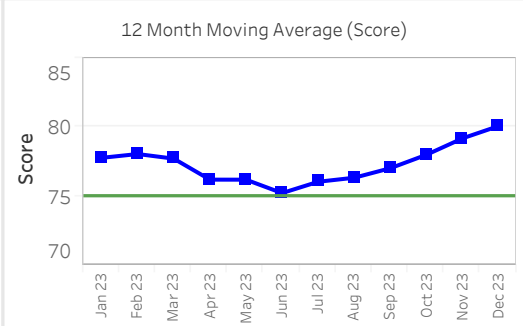
Quality Department | Note : updated as of January 23, 2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

December 2023 (unless other specified)

Month to Board Quality Committee : February 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise) Latest Month : December 2023	MV : 172 mins	MV : 177 mins	MV : 194 mins	MV : 191 mins		
	LG : 132 mins	LG : 134 mins	LG : 142 mins	LG : 139 mins		
	ENT : 152 mins	ENT : 156 mins	ENT : 168 mins	ENT : 165 mins		
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : December 2023	78.6	82.1	78.5	76.4		
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : December 2023	82.8	81.5	75.0	75.0		

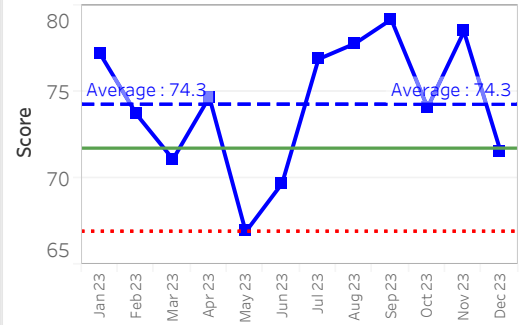
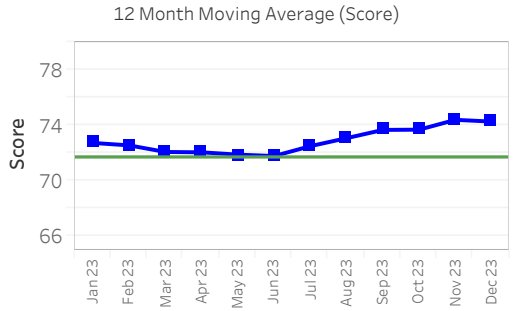
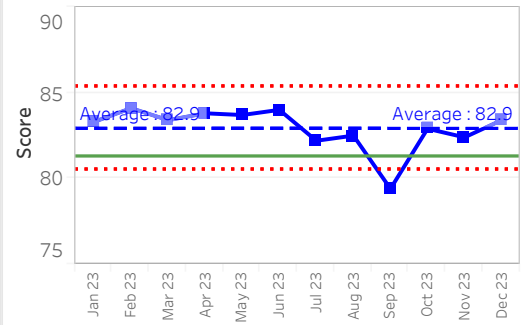
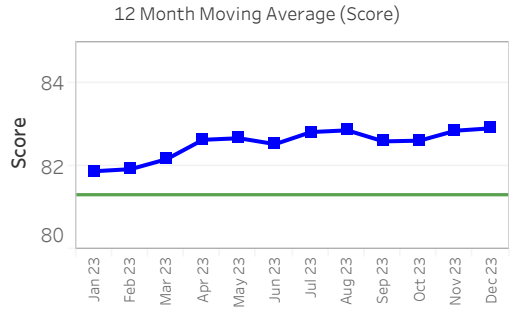
Quality Department | Note : updated as of January 23, 2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

December 2023 (unless other specified)

Month to Board Quality Committee : February 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend		FYTD or Rolling 12 Month Average
	Latest Month	FYTD					
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : December 2023	71.6	76.2	71.7	71.7	BETTER		BETTER	
*Organizational Goal ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : December 2023	83.4	82.1	82.7	81.3	BETTER		BETTER	

Quality Department | Note : updated as of January 23, 2024

Measure	Definition Owner	Metric Definition	Data Source
*Organizational Goal HAC Index 2.0	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) 25%, Catheter Associated Urinary Tract Infection (CAUTI) 25%,Central Line Associated Blood Stream Infection (CLABSI) 25%, and non-ventilator hospital-acquired pneumonia (nvHAP) 25%,	See below
HAC Component Clostridium Difficile Infections (C-Diff)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
HAC Component Catheter Associated Urinary Tract Infection (CAUTI)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator**: Infection control Dept. **Denominator**: EPIC Report

Measure	Definition Owner	Metric Definition	Data Source
HAC Component Central Line Associated Blood Stream Infection (CLABSI)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
HAC Component non-ventilator Hospital-Acquired Pneumonia (nvHAP)	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 4) Latency: periodic; corrections may change previously reported results.	EPIC Clarity data warehouse; **Numerator** identified by nvHAP workgroup; **Denominator**: EPSi patient days nvHAP Tableau Dashboard maintained by: **Mohsina Shakir**
Surgical Site Infections (SSI)	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

Measure	Definition Owner	Metric Definition	Data Source
Serious Safety Event Rate (SSER)	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 Safety Event Tableau Dashboard maintained by: **Michael Moa**
Readmission Index (All Patient All Cause Readmit) Observed / Expected Premier Care Sciences Standard RA	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.	Premier Quality Advisor Readmission Tableau Dashboard maintained by: **Steven Sun**
Mortality Index Observed / Expected Premier Care Sciences Standard RA	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

Measure	Definition Owner	Metric Definition	Data Source
Sepsis Mortality Index Observed / Expected Premier Care Sciences Standard RA	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
PC-02 : Cesarean Birth	H. Freeman	1) **Numerator**: Patients with cesarean births 2) **Denominator**: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	CMQCC
PC-05 : Exclusive Breast Milk Feeding	H. Freeman	1) **Numerator**: Newborns that were fed breast milk only since birth 2) **Denominator**: Single term newborns discharged alive from the hospital	CMQCC

Measure	Definition Owner	Metric Definition	Data Source
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)	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 ED Tableau Dashboard maintained by: **Hsiao-Lan (Dee) Shih**
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	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
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	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

Measure	Definition Owner	Metric Definition	Data Source
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	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
*Organizational Goal ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	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

Final Notes:
1.) SSER through October 2023
2.) Readmissions through November 2023
3.) PC-02 & PC-05 through November 2023
4.) Updated as of 2024-01-23

El Camino Health

FY24 Quarterly Board Quality Dashboard (STEEEP)

Quality Domain	Metric		Past Performance				Baseline	Target	Current Performance		
			FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	FY 23	FY 24	FY24 Q1	FY24 Q2	FYTD
Safe Care	HAC Index 2.0 Score		1.358	1.451	1.238	0.861	1.238	**1.201**	1.130	1.460	**1.300**
	HAC Component: Cdiff Weighted (25%) Rate (per 10,000 Patient Days)		0.627	1.165	0.874	0.629	0.830	**0.805**	0.649	1.112	**0.880**
	HAC Component: CAUTI Weighted (25%) Rate (per 1,000 Urinary Catheter Days)		0.136	0.162	0.218	0.177	0.171	**0.166**	0.356	0.192	**0.277**
	HAC Component: CLABSI Weighted (25%) Rate (per 1,000 Central Line Days)		0.511	0.000	0.080	0.000	0.154	**0.150**	0.000	0.075	**0.039**
	HAC Component: nvHAP Weighted (25%) Rate (per 1000 Patient Days)		0.084	0.124	0.066	0.055	0.082	**0.080**	0.125	0.081	**0.103**
	SSI Rate (per 100 surgical procedures) *(not part of HAC Index)*		0.314	0.552	0.196	0.463	0.380	**0.369**	0.564	0.301	**0.431**
Timely	Lab STAT Troponin TAT for ED (received to verification)		93.8%	88.8%	70.9%	78.0%	82.7%	**90.0%**	84.2%	81.3%	**82.7%**
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)		78.4%	78.3%	78.3%	77.0%	78.0%	**84.0%**	76.3%	76.5%	**76.4%**
Effective	Risk Adjusted Readmissions Index		1.05	1.18	1.05	1.09	1.09	**1.00**	1.14	1.13* (Oct-Nov)	**1.13* (July-Nov)**
	Risk Adjusted Mortality Index		1.03	1.14	1.19	1.14	1.13	**1.00**	1.00	1.13	**1.07**
	Risk Adjusted Sepsis Mortality Index		1.02	1.37	1.26	1.15	1.20	**1.00**	1.07	1.32	**1.20**
	PC-02 NTSV C-Section		28.8%	24.7%	24.0%	30.2%	27.0%	**23.9%**	26.6%	23.2%	**25.2%**
Efficient	Length of Stay O/E		1.19	1.16	1.22	1.19	1.19	**1.15**	1.19	1.22	**1.20**
	Median Time from ED Arrival to ED Departure (Enterprise)		174 min	167 min	168 min	164 min	168 min	**165 min**	157 min	154 min	**156 min**
Equitable	Homeless Discharge Clothing Documentation Compliance		----	----	----	----	----	**100.0%**	53.0% (184/347)	69.0% (240/348)	**61.0%** (424/695)
	Quality Council Health Equity Item Included in PI efforts (% of depts)		----	----	----	----	----	**50.0%**	0.0% (0/7)	33.3% (4/12)	**21.1%** (4/19)
	Sepsis Bundle Compliance by Race	Asian	----	----	----	----	----	**----**	77.8% (28/36)	75.0%* (12/16) (Oct-Nov)	**76.9%* (40/52) (July-Nov)**
	Sepsis Bundle Compliance by Race	Hispanic	----	----	----	----	----	**----**	93.3% (14/15)	81.3%* (13/16) (Oct-Nov)	**87.1%* (27/31) (July-Nov)**
	Sepsis Bundle Compliance by Race	White	----	----	----	----	----	**----**	86.6% (84/97)	82.8%* (53/64) (Oct-Nov)	**85.1%* (137/161) (July-Nov)**
	Sepsis Bundle Compliance by Race	Others	----	----	----	----	----	**----**	61.1% (11/18)	70.0%* (7/10) (Oct-Nov)	**64.3%* (18/28) (July-Nov)**
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend		79.9	78.8	76.6	78.4	78.5	**76.4**	84.0	80.3	**82.1**
	ED - Likelihood to Recommend (PG)		70.3	72.3	73.8	70.4	71.7	**71.7**	77.9	74.5	**76.2**
	MCH - HCAHPS Likelihood to Recommend		72.3	72.1	83.7	74.0	75.0	**75.0**	79.7	83.7	**81.5**

Updated: 01/23/24

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

Legend:

- **Green: At or exceeding target**
- **Yellow: Missed target by 5% or less**
- **Red: Missed target by > 5%**
- **White: No target**

El Camino Health

Quality Domain	Metric		Metric Definition
Safe Care	HAC Index 2.0 Score		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%.
	HAC Component: Cdiff Weighted (35%) Rate (per 10,000 Patient Days)		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.
	HAC Component: CAUTI Weighted (*15%*) Rate (per 1,000 Urinary Catheter Days)		1) Based on NHSN defined criteria 2) Exclusions : ED & OP
	HAC Component: CLABSI Weighted (15%) Rate (per 1,000 Central Line Days)		1) Based on NHSN defined criteria 2) Exclusions : ED & OP
	HAC Component: nvHAP Weighted (35%) Rate (per 1000 Patient Days)		≥ 3 days hospitalization & Not receiving mechanical ventilation. Evidence of order or procedure code for chest X-ray or computerized tomography of the chest. Administration of selected antimicrobials (e-Table 3) not previously administered in past 2 days and continued for ≥3 days (changes in antibiotics permitted during the 3 day period so long as each new agent was not used in the preceding 2 days). More detailed and specific definition can be provided.
	SSI Rate (per 100 surgical procedures) *(not part of HAC Index)*		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.
Timely	Lab STAT Troponin TAT for ED (received to verification)		A metric that assists with ED through-put and timely diagnosis of cardiac injury. The measurement begins with a time stamp of the specimen being received in the clinical laboratory and ends with a time stamp of the Troponin result being released to EPIC.
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)		Imaging TAT Criteria : TAT from Exam END to Exam Finalized, Routine orders only. Qualified exam won't include the exams that Prelim or ED Wet Read exists. On Target as defined as ED - <= 45 min. Over Target is defined as ED > 45 min. ED encounters
Effective	Risk Adjusted Readmissions Index		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.
	Risk Adjusted Mortality Index		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.
	Risk Adjusted Sepsis Mortality Index		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)
	PC-02 NTSV C-Section		1) Numerator: Patients with cesarean births 2) Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation
Efficient	Length of Stay O/E		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.
	Median Time from ED Arrival to ED Departure (Enterprise)		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
Equitable	Homeless Discharge Clothing Documentation Compliance		EMTALA - Homeless Discharge Navigator. Specifically for Clothing documented and compliance. Epic data source.
	Quality Council Health Equity Item Included in PI efforts (% of depts)		Departments that present a Health Equity (HE) -related item during Quality Council presentation / total departments presented
	Sepsis Bundle Compliance by Race	Asian	Sample of patients age >18 years, presenting in the Emergency Dept or In-patient unit with Severe Sepsis/Septic Shock (Suspected or known infection, 2+SIRS, 1 new organ dysfunction). Retrospective or concurrent chart reviews identified from one or more of the following: Emergency Room work up/differential, admitting diagnosis, Sepsis Alert, safety reporting system, EHR surveillance, iCare reporting, ICD-10 discharge code. Time of Presentation(TOP): time at which all criteria for severe sepsis are present, OR provider documentation of severe sepsis, whichever is earliest. Race is as defined of patient registration input, collected & documented in Epic.
	Sepsis Bundle Compliance by Race	Hispanic	
	Sepsis Bundle Compliance by Race	White	
	Sepsis Bundle Compliance by Race	Others	
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend		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'
	ED - Likelihood to Recommend (PG)		ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted'
	MCH - HCAHPS Likelihood to Recommend		Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted'

El Camino Health

HAC-A-Thon: C.diff

Look for the Green, Keep it Clean!

Look for the **GREEN** Contact Precautions sign for C.diff outside the patient's room and on the sanitizer station inside the room!

Infection Prevention

- The single most important way to prevent infection is **HANDWASHING!**
  - Remove PPE (gown/gloves) before handwashing upon exit
  - **Soap and water only**, wash for 40-60 seconds (no gel)
- Disinfect all surfaces and equipment
  - Use bleach (**orange top**) wipes to clean
- Use disposable equipment when applicable

Refer to Procedure: Management of C. diff Infection
For questions, contact Infection Prevention or Education Department

Prenatal Education | Maternal Child Health

Healthy Pregnancy for South Asian Families Class Series

A Virtual Four-Class Series designed for you and your family!

Join us to learn more about nutrition, exercise and preparing for birth. This series is designed as three classes to be taken over different stages of your pregnancy with a fourth class to be taken after your baby is born.

Learn from an experienced midwife and childbirth educator, a prenatal nutritionist, a labor and delivery nurse certified in prenatal exercise, and a certified lactation consultant in this series of classes as you progress through your pregnancy with us. The information is tailored to South Asian families but the classes are open to everyone.

- Class 1: Early 2nd trimester (~14-16 weeks)
- Class 2: Late 2nd trimester (~24-26 weeks)
- Class 3: Early 3rd trimester (~34-36 weeks-
- Class 4: Postpartum (~4-6 weeks after delivery)

Sign up for the four-class series via Course Storm:
https://elcaminohealth.coursestorm.com/category/maternal-child-education

4 Class Series Cost: $100/family

El Camino Health®

Mother-Baby Health
2500 Grant Road | Mountain View, CA 94040 | 650-940-7000
815 Pollard Road | Los Gatos, CA 95032 | 408-378-6131
elcaminohealth.org/maternity

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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: February 5, 2024
Subject: Enterprise Quality, Safety and Experience and STEEEP Dashboards through December 2023

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety, and experience measure performance through December 2023 (unless otherwise noted). This memo will describe performance from both the STEEEP and Enterprise Quality Dashboards.

Situation:

The FY 23 Enterprise Quality, Safety and Experience Dashboard is updated monthly and tracks nineteen quality measures. The STEEEP dashboard is updated each quarter and contains twenty measures. The STEEEP dashboard is intended to be a Governance Level report, which is shared with the El Camino Hospital Board of Directors on behalf of the Quality Committee once a quarter. Most measures are tracked on both the Enterprise monthly and STEEEP quarterly dashboards.

A. Safe Care

Hospital Acquired Condition Index 2.0

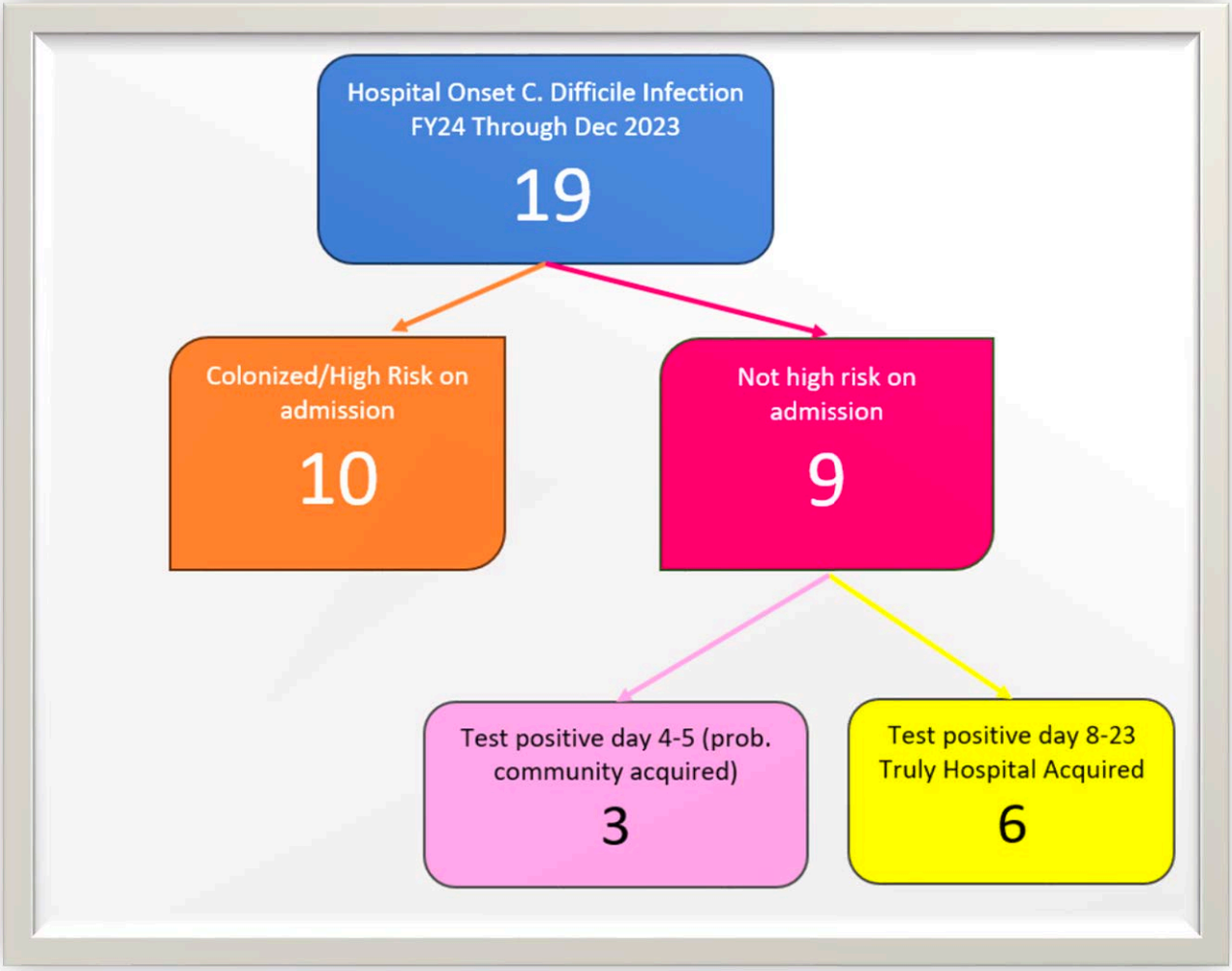
This measure is a composite of four measures as illustrated below.

FY 24 HAC 2.0 weighting and targets			
Component	**Denominator**	**Weighting**	**Weighted Rate**
CLABSI	per 1,000 central line days	25%	aa
CAUTI	per 1,000 catheter days	25%	bb
C. Diff	per patient days x 10,000	25%	cc
nvHAP	per patient days x 1,000	25%	dd
		SUM	HAC Index

1. HAC Index 2.0 is the strategic quality and safety goal for FY24. For the month of December (1.284) and Fiscal Year-To-Date (1.300) we are unfavorable to target of (1.201)

    1.1. **C. Difficile Infection:** The C. Diff rate per patient days x 10,000 (1.112) for the second quarter and year to date (0.880) are unfavorable to target (0.805). There have been 19 hospital acquired infections in FY24. Of these 19 C. Difficile infections, six were likely

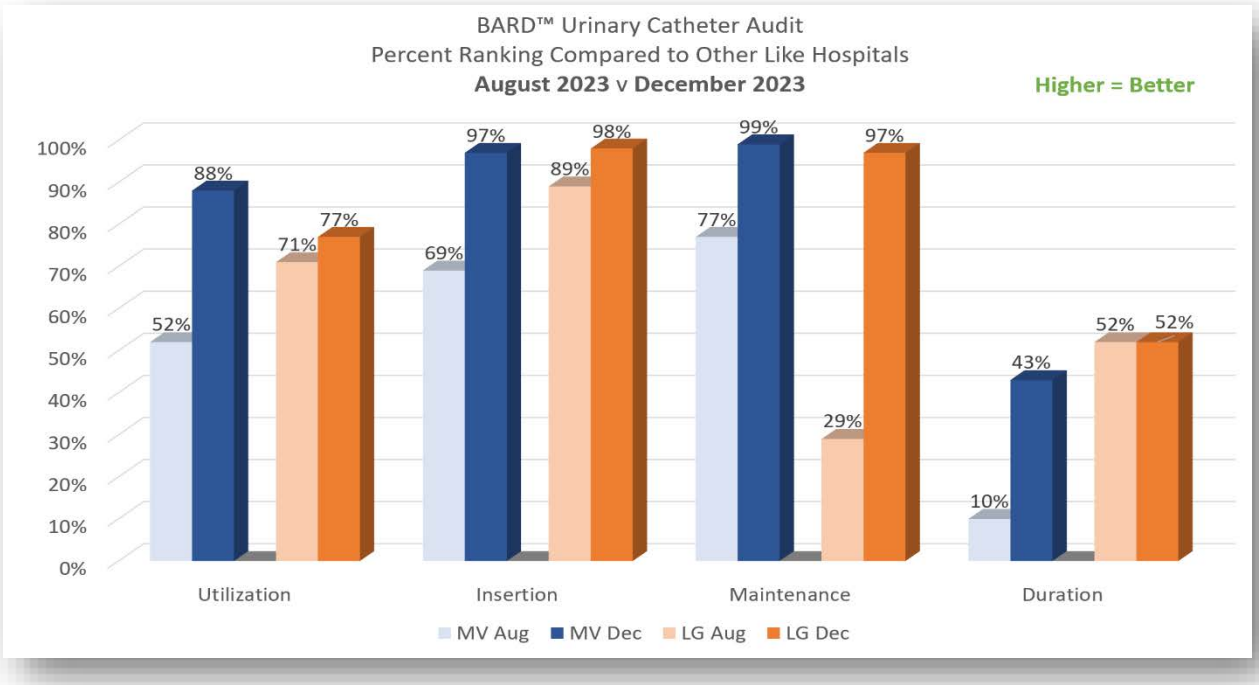
preventable. Areas of focus to decrease C. Diff are twofold. First, hospital wide



education on C. Diff screening, testing and prevention. (See attachment: CdiffHAC2-24 Education Flyer) Second, deployment of enterprise-wide hand hygiene program. A detailed report describing the hand hygiene process improvement initiative is included in the consent agenda portion of the packet as a Quality Committee follow up item.

1.2. **Catheter Associated Urinary Tract Infection (CAUTI):** The rate of catheter associated urinary tract infection per catheter days for Q2 (0.192) is significantly improved from Q1 (0.356) and is approaching target (0.166). As of January 29, 2024, it has been 56 days since the last CAUTI in Mountain View and 176 days since the last CAUTI in Los Gatos. There have been nine CAUTI year to date with a goal to have less than twelve for the fiscal year. There were four infections in July, and one per month in August through December 2023. Eight of the nine patients with CAUTI were profoundly ill and unstable resulting in an ICU stay and close fluid management via prolonged utilization of a urinary catheter (> 3 days). Having too much or too little intravascular fluid can result in catastrophic damage to the lungs, kidneys, and heart. Close fluid management involves meticulous measurement of fluids going in and fluid

going out (urine). The most accurate way to monitor urine output to be accurate to the milliliter is via an indwelling urinary catheter.
Process improvement foci to reduce CAUTI are 1. Remove catheters as soon as possible when clinically appropriate, and 2. Ensure insertion and maintenance best practices are followed. To achieve shorter catheter duration, our infection prevention team rounds on every single patient with a catheter in for greater than three days and collaborates with the nurse and physician to review indications for the catheter and direct attention to the importance of removing the catheter as soon as clinically appropriate. This intervention is likely contributing the improved performance in the second quarter of FY24. Optimizing catheter insertion and maintenance performance has been achieved through partnership amongst our Infection Prevention team, unit champions and BARD™, the vendor who provides our catheters. We requested an independent audit from BARD™ of our catheter practices in August 2023 with a re-visit and audit in December 2023. There has been significant improvement in the 4-month interval between audits. The results are depicted in the bar graph below which illustrates our percentile ranking compared to other like hospitals in catheter best practices. You will appreciate that the domain of catheter duration is where we continue to have the greatest opportunity. This informs our focus on removing catheters timely when clinically appropriate. "When in doubt, take it out!"



1.3. **Central Line Associated Blood Stream Infection (CLABSI)**. The rate of CLABSI for second quarter (0.075) and year to date (0.039) are favorable to target (0.150). There has been one CLABSI year to date. This time in FY23 there were seven CLABSIs. The isolated CLABSI was in a NICU patient whose mother was colonized during pregnancy with the same organism which grew in the central line. This suggest the neonate was colonized at birth and this was likely not a hospital acquired infection. Per CDC guidelines, however, we count it this as a CLABSI. Our focus, to sustain our favorable

CLABSI performance, is on optimizing care and management hemodyalsis catheters. In FY23 the majority of CLABSIs were related to hemodyalsis catheters.

1.4. **Non-ventilator Hospital-Acquired Pneumonia (nvHAP).** The FY24 Q2 nvHAP rate (0.081) improved from Q1 (0.125) and is approaching target (0.080). Two interventions, mobilizing our patients out of bed, and having regular oral care are in place. Both practices are contributing to the successful decrease in nvHAP infections affecting our patients.

2. **Surgical Site Infection**. The rate of surgical site infections for FY23 Q2 (0.31) is favorable to target (0.369). There have been no total knee replacement (TKR) infections in FY24. As of January 29, 2024, it has been 294 days since the last TKR infection in Los Gatos and 271 days in Mountain View. Process improvement has included staff education on hand hygiene, surgical attire, and sterile equipment processing. These initiatives have decreased surgical site infections for TKR surgeries. The OR departments are continuing their work on vendor behavior and reducing traffic and door opening during orthopedic joint replacement surgical procedures.

B. Timely

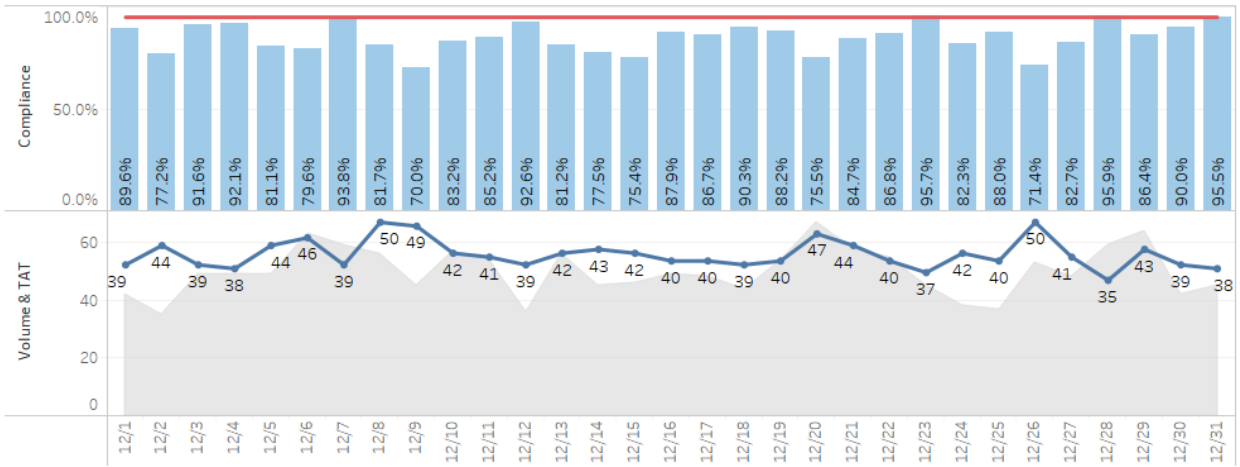
1. **Lab STAT Troponin Turnaround Time for Emergency Department (received to verification).** [1]The goal is to have 90% of results back within (40 minutes). Performance in Q2 FY24 (81.3%) is unfavorable to target. Below is a detailed analysis of gaps and corrective actions to improve our performance.

What is affecting our TAT?		
Item	**Description**	**Corrective Action**
DxI Downtime (Analytical Instrument Running Troponin Test x2) **OR** **DxA Downtime (Chemistry line processing the specimens for testing on the DxI)**	We continue to experience downtimes for our DxI & DxA instrumentation. Increase in TAT may be seen when at least 1 instrument is down or if the line is down/partial down. Details of errors can be sent on request.	Continue to monitor downtimes and escalate to vendor ones that we frequently see.
High Troponin Values	Troponin values above a certain threshold is at risk for cross-contamination between subsequent specimens tested.	The manufacturer is aware of this limitation, and we have escalated for a resolution multiple time.

[1] A troponin test measures the levels of troponin proteins in the blood. These proteins are released when the heart muscle has been damaged, such as occurs with a heart attack. The more damage there is to the heart, the greater the amount of troponin there will be in the blood. Outcomes of patients experiencing a heart attack (myocardial infarction) in the ED improve when interventions occur timely. Having the results of troponin blood test within 40 minutes to inform care team of the patient's cardiac status enables timely intervention.

	When identifying a high troponin value, we are required to remove the reagent from the instrument and perform maintenance to eliminate cross-contamination risks. This takes time to perform.	Currently no update on their end for a resolution.
Maintenance	Maintenance of the DxI or DxA will require periodic downtimes. The time for maintenance may be increased due workload as the staff have to juggle both maintenance and releasing of patient results. Delays can be exacerbated with staffing shortages.	Beckman Coulter to help identify process improvement opportunities in the next month.
Critical Calls	Critical calls affect our TAT as we release the result to the patient only after we make the phone call to the care team. Depending on the capacity for the unit to quickly answer the call, this will delay our release times (affecting this metric).	Now, we are calling a large number of troponin results. We are working with the cardiovascular service line to adjust the critical call threshold.

Daily metric for Troponin TAT for December 2023



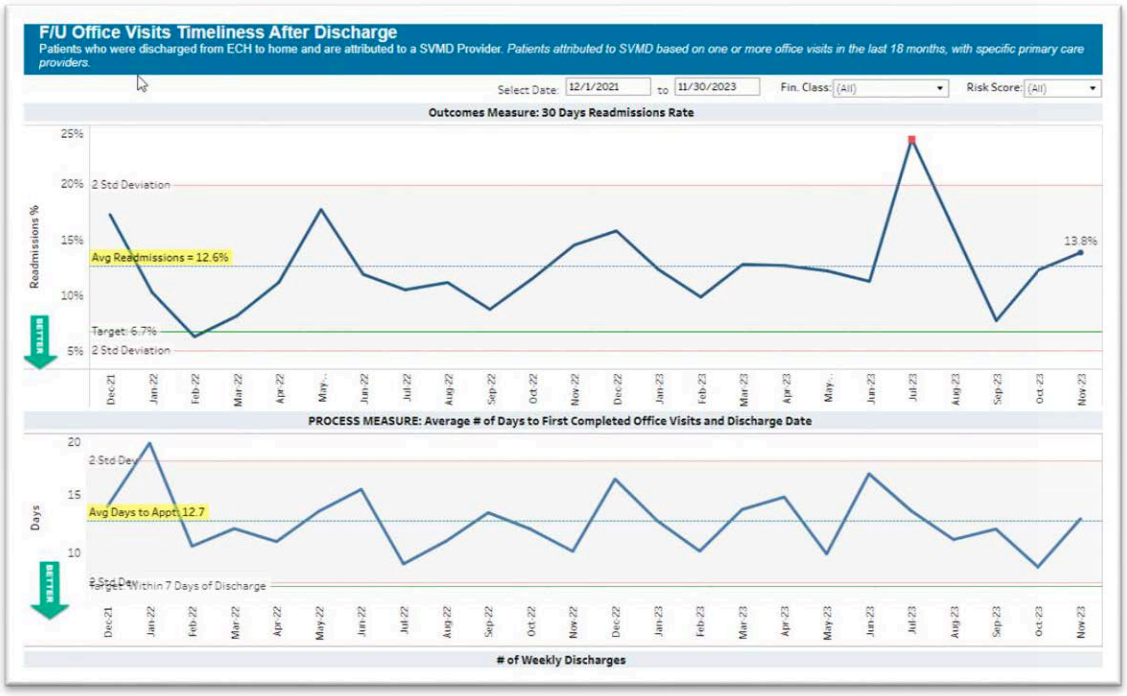
2. Imaging Turnaround Time: ED including X Ray (target + % completed <= 45 minutes). Performance for Q2 (76.5%) and YTD (76.4%) are unfavorable to target (84%). Root cause of the delays relates to the suboptimal performance of the 'night hawk' radiology vendor who performs readings for the hospitals after hours. A transition to the new nighttime partner will take effect February 13, 2024. Within 3-months of this transition, we anticipate a significant improvement (decrease) in reading times.

C. Effective

1. Risk Adjusted Readmission Index. Performance through November YTD (1.13) is unfavorable to target (1.0). Having timely follow-up with a clinician within 14 days of discharge decreases readmissions. A recent publication demonstrated a 42% decreased risk of being readmitted within 30 days of discharge for those patients seen in a post discharge clinic within 14 days of discharge. (Michael Baldino D.O., April 2021)

> *Avoidable 30-day readmissions cost the Center for Medicare and Medicaid Services (CMS) $17 billion per year.[1] As a result, the Hospital Readmission Reduction Program (HRRP) was enacted in 2012 as a part of the Patient Protection Affordable Care Act.[2] This directive set penalties for hospitals with excess readmissions for diagnoses commonly associated with adverse events. (Michael Baldino D.O., April 2021)*

El Camino Health teams are focused on ensuring patients who have an SVMD primary care provider have timely follow up post discharge. The readmission rates for these patients tracks closely with their ability to be seen timely after discharge. See screenshot below “F/U Office Visits Timeliness After Discharge” from the tableau dashboard created by Steven Sun (Director Clinical Data Analytics) and his team. The top chart shows readmission rates for SVMD patients following hospitalization at ECH. The bottom chart shows the average number of days between discharge and follow up appointment with SVMD primary care physician. Animating the benefits for our patients of being an enterprise, the ECH ambulatory and inpatient teams are collaborating to optimize navigation and integration of care between the hospital and clinic setting.



2. Risk Adjusted Mortality Index. Performance for FY24Q2 (1.13) and YTD (1.07) are unfavorable to target (1.00). Mortality index tracks, and for this time frame, is driven by the sepsis mortality.

3. Sepsis Mortality Index. Performance for FY24Q2 (1.32) and YTD (1.20) is unfavorable to target (1.0). You may recall from the focused review on sepsis shared with you in November 2023, that compliance with the 7 elements of the sepsis bundle correlates strongly with patient outcomes. Bundle compliance for both campuses remains excellent through FY23Q2. Every single sepsis mortality is reviewed. Reviews from the past quarter highlight that patients are being transferred from SNFs to ECH to die with end stage complications of disease and sepsis. There is no change in care or attention to bundle compliance which would have prevented these end-of-life patients from expiring. To provide better care to end-of-life patients and their families we are looking forward to the re-establishment of a comprehensive inpatient hospice program (GIP—General Inpatient Care) now that our new Medical Director of Palliative care joined the organization in November 2023. If a terminal patient presents at the end of life, and we have the capability of caring for the patient and their family in an inpatient hospice setting, the support for the patient, and the impact on our mortality measurement is favorable. Patients admitted to GIP are no longer counted in the mortality tracking. We are doing an excellent job of caring for patients with sepsis. We have an opportunity to improve the support we provide to patients and their families at the end of life through a robust GIP program.

4. PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV). Since assuming the inaugural role of Chief Quality Officer for ECH in November 2021, this is the first time I have born witness to a cesarean section rate of 23.2% for nulliparous women having a singleton vertex pregnancy! The FY24Q2 performance (23.2%) is favorable to target of 23.9%. The maternal child health service line is a leader in recognizing and addressing the cultural norms

and expectations of our patients in how they view, engage with and approach health care. Greater than 63% of patients who deliver at ECH are Asian. In our experience, South Asian patients have a low tolerance for the uncertainties, risks, and pain involved with a vaginal delivery and low threshold for requesting a cesarean section. The MCH team, in recognition of the preferences and perspectives of our South Asian maternity patients, has created a culturally sensitive and clinically appropriate pre-natal childbirth education program for S. Asian expectant families. Please see attachment 4, *Health Pregnancy for South Asian Families*.

D. Efficient

1. **Length of Stay O/E (LOS O/E).** Length of stay is a measure of operational efficiency. The quality of care a patient receives is reliant on the navigation, coloration and efficiency achieved through operational excellence. Having timely, coordinated, and appropriate care has a profound impact on the overall quality of care our patients receive. Performance YTD (1.20) is unfavorable to target (1.15). A formidable challenge to decreasing length of stay for patients whose discharge disposition is a skilled nursing facility (SNF) are the barriers payors have in place to authorize timely discharge to a SNF. Our teams our optimizing care coordination within our system to decrease length of stay. Here are specific interventions in place:
    - We have created a centralized care plan in Epic that pulls together important information about the patients care plan. Information includes the medical care plan for the day, rehab recommendations, discharge destination, social drivers of health, and estimated date of discharge. This tool allows the care team to obtain pertinent information in a timely way without having to dig through the chart. Additionally, we are tracking delays to obtain more insight into the primary reasons for delays in patient throughput.

    - Multidisciplinary rounds (MDR) have been activated on 2C, and they continue in Los Gatos. Both teams have incorporated use of the centralized care plan in MDR. At the 30-day check-in we have seen a significant LOS decrease of **-0.5 days** on 2C for the pilot population.

    - We now have 3 skilled nursing facility transfer agreements in place (Cedar Crest, Grant Cuesta and Mountain View Health Care). These agreements help us expedite discharge to SNF for the self-pay and MediCal patients. We transfer about 3-4 patients per month utilizing the transfer agreements and are working to increase utilization of the transfer agreements.

    - The discharge lounge continues to be open Monday-Friday and nursing and case management work together to identify appropriate patients who can discharge to the lounge to help expedite discharges and increase bed capacity.

2. **Median Time from ED Arrival to ED Departure (Enterprise).** The current FY24Q2 performance (154 minutes) and YTD (156 minutes) is favorable to the target of 165 minutes (lower is better). This performance is years in the making with an overhaul of the patient triage process, creation of additional chairs for less acute patients, and, most recently the creation of an ED express area on the Mountain View Campus. The ED express has capacity for 6 patients of lower acuity and will allow our teams to provide more efficient care for patients of lower acuity (treat to street).

E. Equitable

1. **Homeless discharge documentation of providing appropriate clothes.** In Q2 of FY24 documentation of offering weather appropriate clothing to homeless patients prior to discharge has improved from 53% to 69%. The health equity department is partnering with nursing clinical documentation team to reduce the inefficiencies in our EMR build which obfuscate consistent documentation of compliance with our homeless discharge policy.

2. **Quality Council Health Equity Item Included in Process Improvement Efforts (% of departments).** With the return of our Health Equity manager from a medical leave, the health equity team has been able to coach and support departments to include at least one improvement measure viewed through an equity lens. For the second quarter of FY2024 four of twelve departments reported on a health equity measure during their annual performance improvement report at the monthly Quality Council meeting.

3. **Sepsis Bundle Compliance by Race.** We continue to track and learn from segregating some of our quality measures by race, whilst optimizing the accuracy of race data we collect from our patients at the time of registration. The quality of 'race' data provided by our patients must improve prior to deducting meaningful information about sepsis bundle compliance by race. That said, as we continue to track this measure, the increase in the denominator over time will render the measures more meaningful.

F. Other Measures

Patient Experience Measures. Performance in patient experience is favorable to target in our Emergency Department, Maternal Child Health, and Inpatient Units. We continue to exceed our target for our Likelihood to Recommend (LTR) scores across the enterprise due to our continued commitment and focus on our evidence-based best practices. This includes hourly (purposeful) rounding, leader rounding, bedside shift report and enhanced communication using our WeCare practices.

Attachments:

1. Enterprise Quality Dashboard through December 2023
2. STEEEP Dashboard through Q2 of FY2024
3. CdiffHAC2-24 Education Flyer
4. Health Pregnancy for South Asian Families Flyer

Works Cited

Advisory Board. (2022, May). *The State of the Post-Acute Workforce.* Advisory.com.

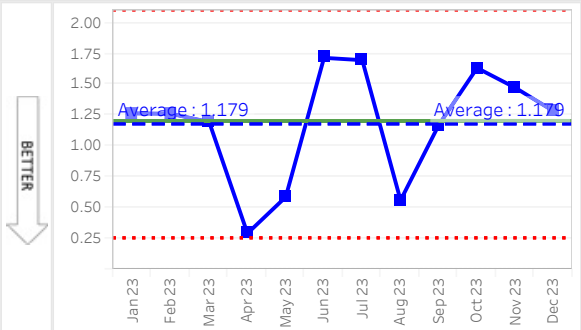
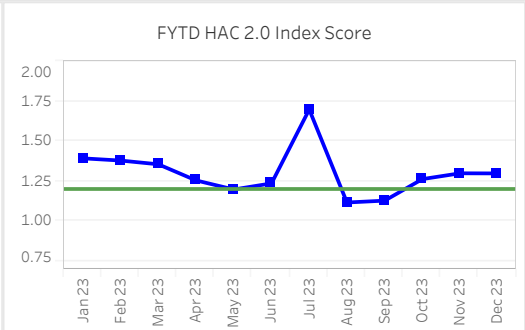
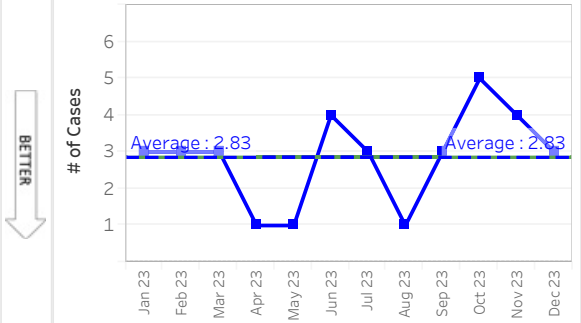
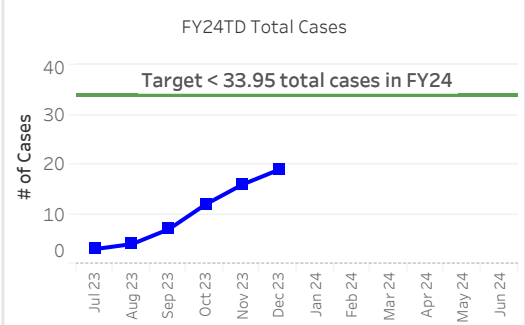
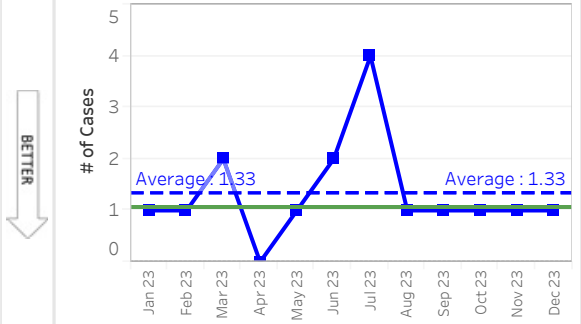
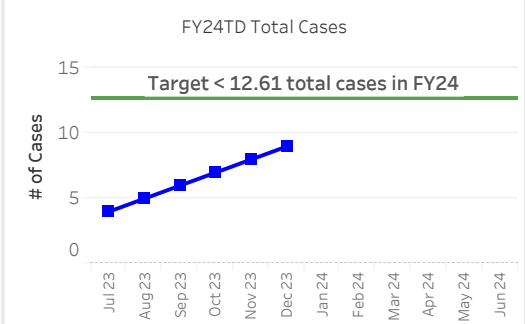
Michael Baldino D.O., M. a. (April 2021). Impact of a Novel Post-Discharge Transitions of Care Clinic on Hospital Readmissions. *Journal of the National Medical Association*, Pages 133-141.

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

December 2023 (unless other specified)

Month to Board Quality Committee : February 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal HAC Index 2.0 Latest Month : December 2023	1.284	1.300	1.238	1.201 (3.0% ↓)		
HAC Component Clostridium Difficile Infections (C-Diff) Latest Month : December 2023	3 cases	3.17 cases/mo	2.92 cases/mo	2.83 cases/mo		
HAC Component Catheter Associated Urinary Tract Infection (CAUTI) Latest Month : December 2023	1 cases	1.50 cases/mo	1.08 cases/mo	1.05 cases/mo		

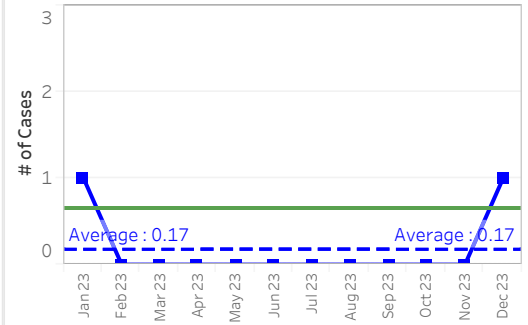
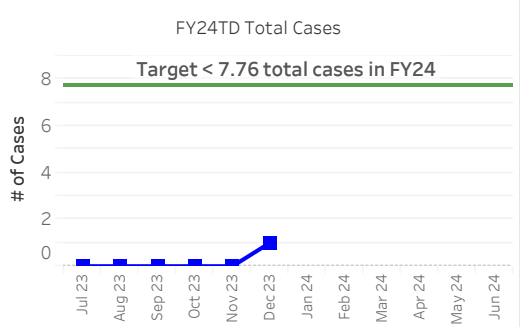
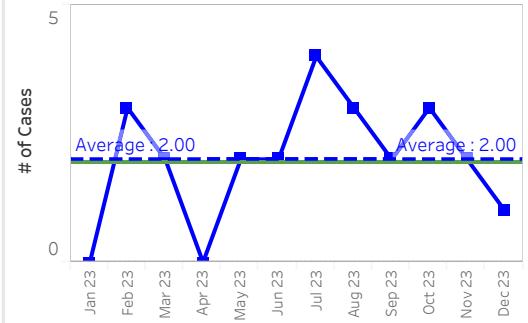
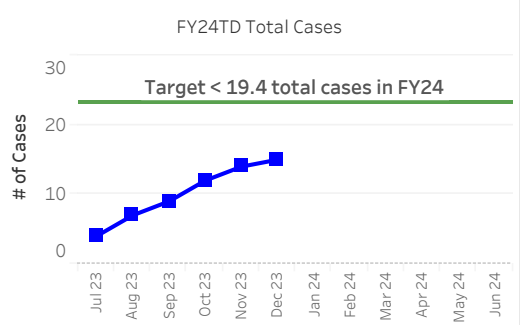
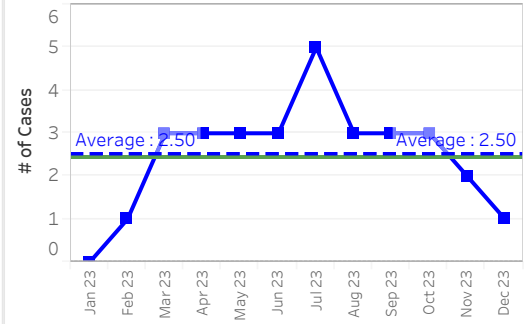
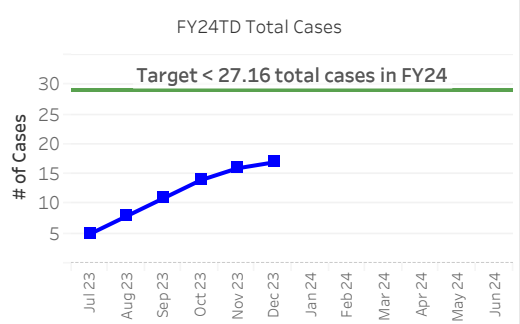
Quality Department | Note : updated as of January 23, 2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

December 2023 (unless other specified)

Month to Board Quality Committee : February 2024

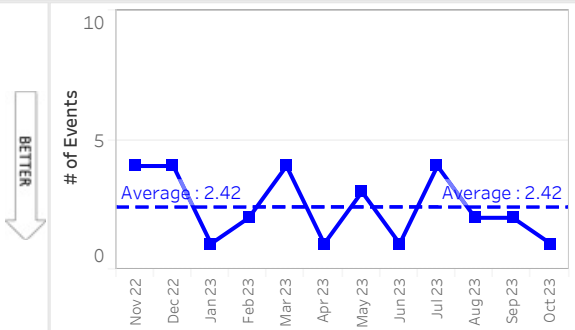
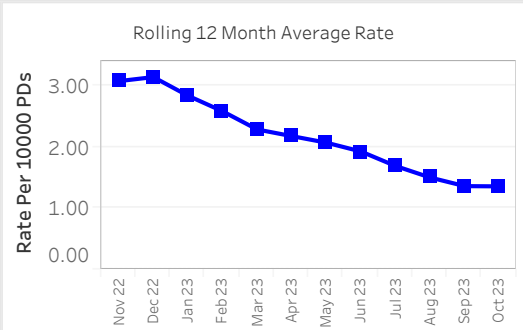
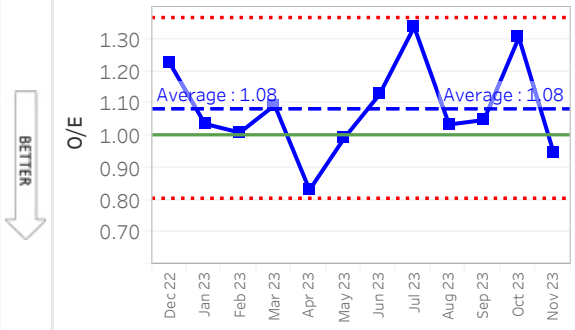
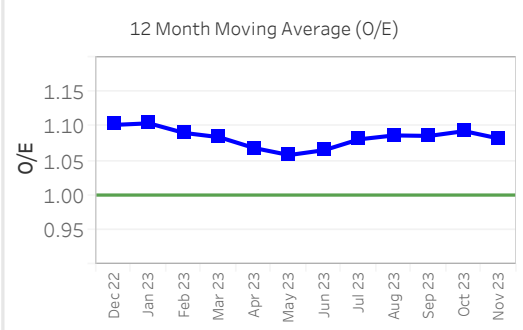
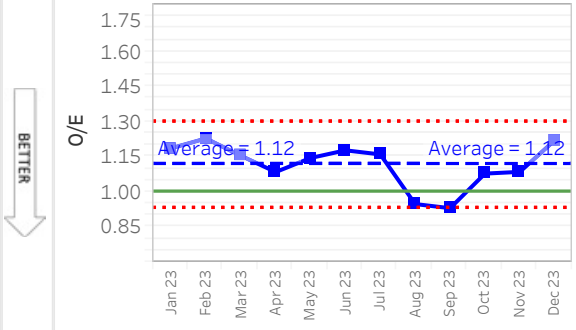
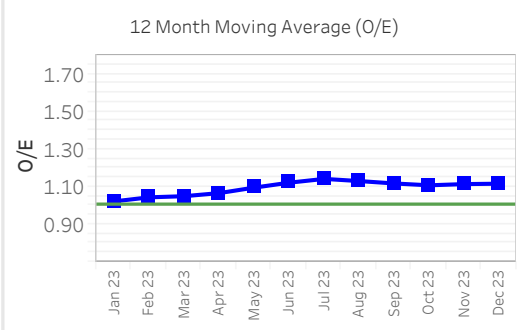
Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
HAC Component Central Line Associated Blood Stream Infection (CLABSI) Latest Month : December 2023	1 cases	0.17 cases/mo	0.67 cases/mo	0.65 cases/mo		
HAC Component non-ventilator Hospital-Acquired Pneumonia (nvHAP) Latest Month : December 2023	1 cases	2.50 cases/mo	2.00 cases/mo	1.94 cases/mo		
Surgical Site Infections (SSI) Latest Month : December 2023	1 cases	2.83 cases/mo	2.50 cases/mo	2.42 cases/mo		

Quality Department | Note : updated as of January 23, 2024

FY24 Enterprise Quality, Safety and Experience Dashboard

December 2023 (unless other specified)

Month to Board Quality Committee : January 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Serious Safety Event Rate (SSER) Latest Month : October 2023	1 events	1.26 (9 / 71355)	1.93 (41 / 212460)	n/a		
Readmission Index (All Patient All Cause Readmit) Observed / Expected Premier Care Sciences Standard RA Latest Month : November 2023	0.95 (7.17% / 7.58%)	1.13 (9.02% / 7.95%)	1.07 (8.47% / 7.94%)	1.00		
Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : December 2023	1.22 (2.78% / 2.28%)	1.07 (2.04% / 1.91%)	1.13 (2.21% / 1.96%)	1.00		

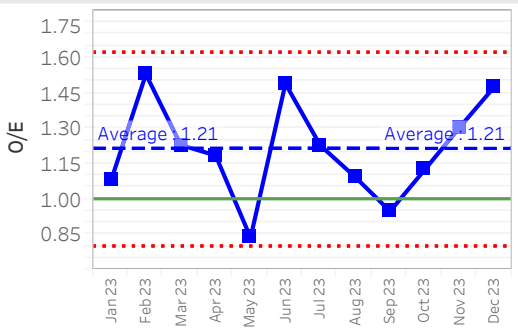
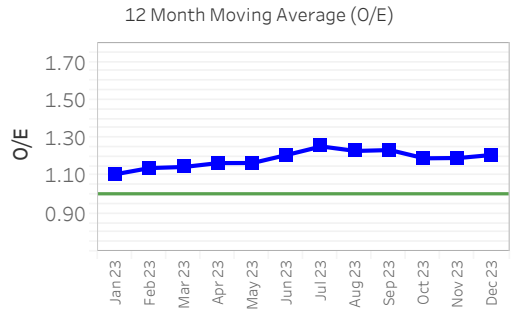
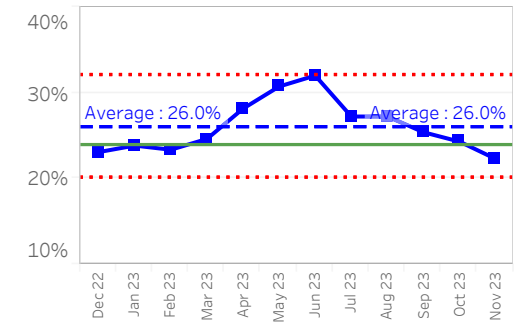
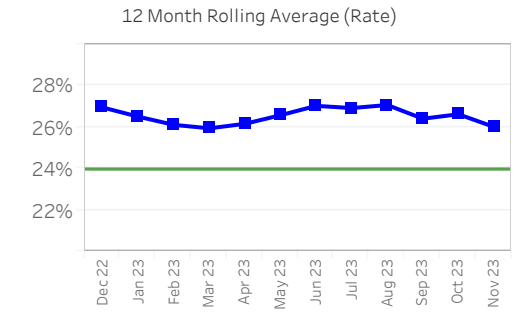
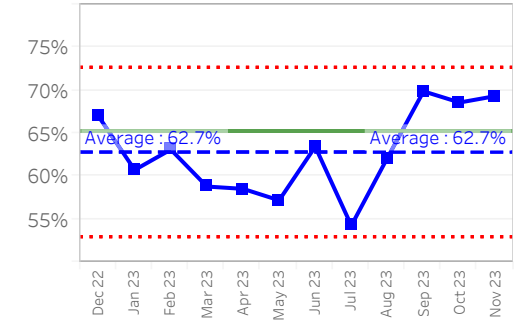
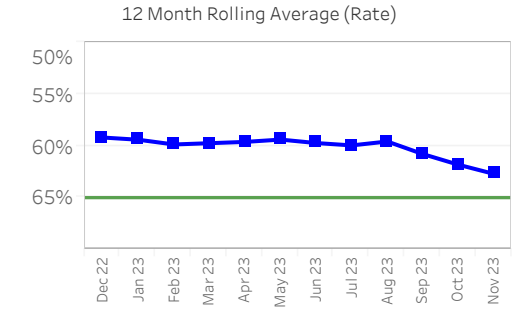
Quality Department | Note : updated as of January 23, 2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

December 2023 (unless other specified)

Month to Board Quality Committee : February 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Sepsis Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : December 2023	1.48 (18.13% / 12.26%)	1.20 (13.73% / 11.44%)	1.21 (14.07% / 11.59%)	1.00		
PC-02 : Cesarean Birth Latest Month : November 2023	MV : 21.9% (40 / 183) LG : 25.0% (7 / 28) ENT : 22.3% (47 / 211)	MV : 26.3% (222 / 845) LG : 17.8% (21 / 118) ENT : 25.2% (243 / 963)	MV : 28.1% (530 / 1883) LG : 20.1% (65 / 323) ENT : 27.0% (595 / 2206)	23.9% (FY24 ENT Target)		
PC-05 : Exclusive Breast Milk Feeding Latest Month : November 2023	MV : 67.7% (210 / 310) LG : 82.1% (32 / 39) ENT : 69.3% (242 / 349)	MV : 66.7% (1023 / 1534) LG : 83.6% (183 / 219) ENT : 65.0% (1127 / 1734)	MV : 58.1% (1966 / 3385) LG : 68.3% (427 / 625) ENT : 59.7% (2393 / 4010)	65.1% (FY24 ENT & MV Target) 70.0% (FY24 LG Target)		

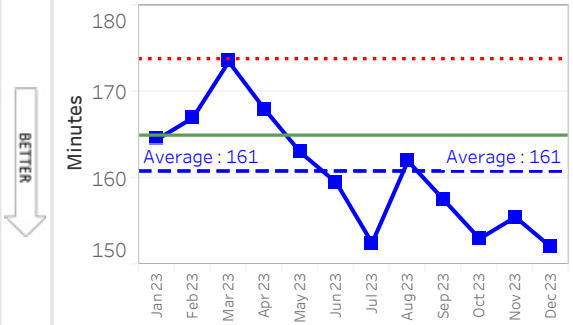
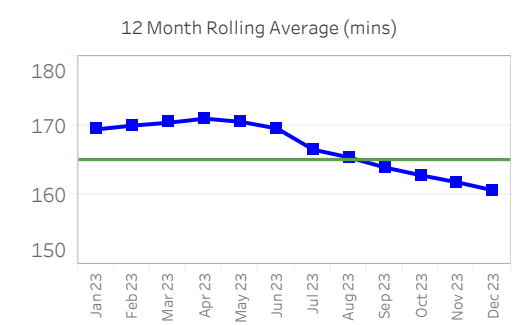
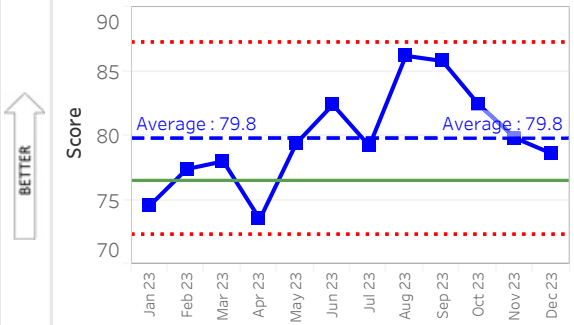
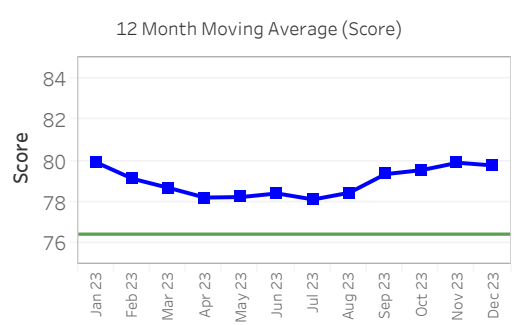
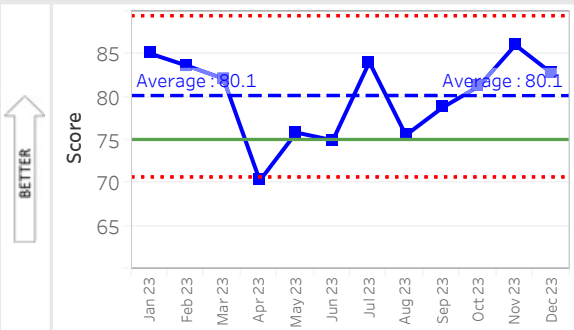
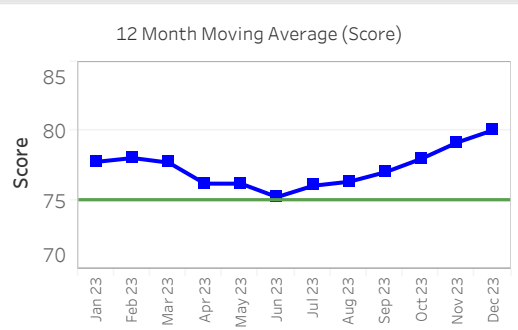
Quality Department | Note : updated as of January 23, 2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

December 2023 (unless other specified)

Month to Board Quality Committee : February 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise) Latest Month : December 2023	MV : 172 mins	MV : 177 mins	MV : 194 mins	MV : 191 mins		
	LG : 132 mins	LG : 134 mins	LG : 142 mins	LG : 139 mins		
	ENT : 152 mins	ENT : 156 mins	ENT : 168 mins	ENT : 165 mins		
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : December 2023	78.6	82.1	78.5	76.4		
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : December 2023	82.8	81.5	75.0	75.0		

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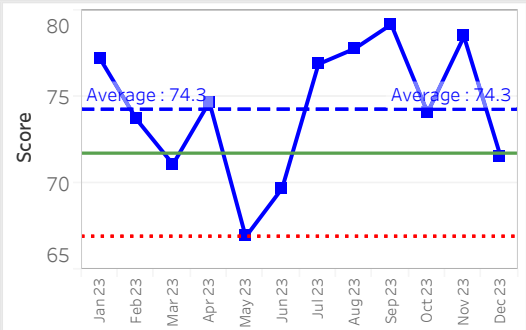
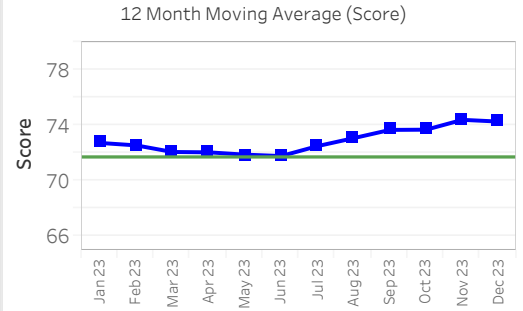
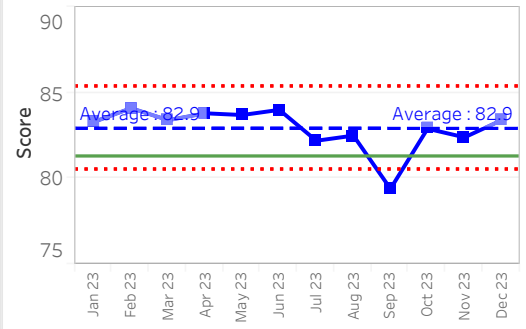
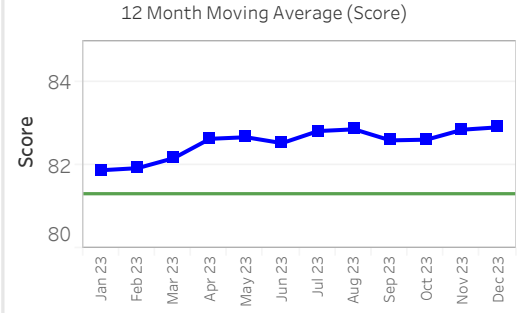
El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

December 2023 (unless other specified)

Month to Board Quality Committee : February 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : December 2023	71.6	76.2	71.7	71.7		
*Organizational Goal ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : December 2023	83.4	82.1	82.7	81.3		

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El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

December 2023 (unless other specified)

Dashboard Managed by
Quality Data Analyst : **Jeffery Jair**
jeffery_jair@elcaminohealth.org

Measure	Definition Owner	Metric Definition	Data Source
*Organizational Goal HAC Index 2.0	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) 25%, Catheter Associated Urinary Tract Infection (CAUTI) 25%,Central Line Associated Blood Stream Infection (CLABSI) 25%, and non-ventilator hospital-acquired pneumonia (nvHAP) 25%,	See below
HAC Component Clostridium Difficile Infections (C-Diff)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
HAC Component Catheter Associated Urinary Tract Infection (CAUTI)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator**: Infection control Dept. **Denominator**: EPIC Report

Measure	Definition Owner	Metric Definition	Data Source
HAC Component Central Line Associated Blood Stream Infection (CLABSI)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
HAC Component non-ventilator Hospital-Acquired Pneumonia (nvHAP)	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 4) Latency: periodic; corrections may change previously reported results.	EPIC Clarity data warehouse; **Numerator** identified by nvHAP workgroup; **Denominator**: EPSi patient days nvHAP Tableau Dashboard maintained by: **Mohsina Shakir**
Surgical Site Infections (SSI)	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

Measure	Definition Owner	Metric Definition	Data Source
Serious Safety Event Rate (SSER)	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 Safety Event Tableau Dashboard maintained by: **Michael Moa**
Readmission Index (All Patient All Cause Readmit) Observed / Expected Premier Care Sciences Standard RA	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.	Premier Quality Advisor Readmission Tableau Dashboard maintained by: **Steven Sun**
Mortality Index Observed / Expected Premier Care Sciences Standard RA	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

Measure	Definition Owner	Metric Definition	Data Source
Sepsis Mortality Index Observed / Expected Premier Care Sciences Standard RA	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
PC-02 : Cesarean Birth	H. Freeman	1) **Numerator**: Patients with cesarean births 2) **Denominator**: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	CMQCC
PC-05 : Exclusive Breast Milk Feeding	H. Freeman	1) **Numerator**: Newborns that were fed breast milk only since birth 2) **Denominator**: Single term newborns discharged alive from the hospital	CMQCC

Measure	Definition Owner	Metric Definition	Data Source
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)	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 ED Tableau Dashboard maintained by: **Hsiao-Lan (Dee) Shih**
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	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
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	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

Measure	Definition Owner	Metric Definition	Data Source
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	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
*Organizational Goal ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	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

Final Notes:
1.) SSER through October 2023
2.) Readmissions through November 2023
3.) PC-02 & PC-05 through November 2023
4.) Updated as of 2024-01-23

El Camino Health

FY24 Quarterly Board Quality Dashboard (STEEEP)

Quality Domain	Metric		Past Performance				Baseline	Target	Current Performance		
			FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	FY 23	FY 24	FY24 Q1	FY24 Q2	FYTD
Safe Care	HAC Index 2.0 Score		1.358	1.451	1.238	0.861	1.238	**1.201**	1.130	1.460	**1.300**
	HAC Component: Cdiff Weighted (25%) Rate (per 10,000 Patient Days)		0.627	1.165	0.874	0.629	0.830	**0.805**	0.649	1.112	**0.880**
	HAC Component: CAUTI Weighted (25%) Rate (per 1,000 Urinary Catheter Days)		0.136	0.162	0.218	0.177	0.171	**0.166**	0.356	0.192	**0.277**
	HAC Component: CLABSI Weighted (25%) Rate (per 1,000 Central Line Days)		0.511	0.000	0.080	0.000	0.154	**0.150**	0.000	0.075	**0.039**
	HAC Component: nvHAP Weighted (25%) Rate (per 1000 Patient Days)		0.084	0.124	0.066	0.055	0.082	**0.080**	0.125	0.081	**0.103**
	SSI Rate (per 100 surgical procedures) *(not part of HAC Index)*		0.314	0.552	0.196	0.463	0.380	**0.369**	0.564	0.301	**0.431**
Timely	Lab STAT Troponin TAT for ED (received to verification)		93.8%	88.8%	70.9%	78.0%	82.7%	**90.0%**	84.2%	81.3%	**82.7%**
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)		78.4%	78.3%	78.3%	77.0%	78.0%	**84.0%**	76.3%	76.5%	**76.4%**
Effective	Risk Adjusted Readmissions Index		1.05	1.18	1.05	1.09	1.09	**1.00**	1.14	1.13* (Oct-Nov)	**1.13* (July-Nov)**
	Risk Adjusted Mortality Index		1.03	1.14	1.19	1.14	1.13	**1.00**	1.00	1.13	**1.07**
	Risk Adjusted Sepsis Mortality Index		1.02	1.37	1.26	1.15	1.20	**1.00**	1.07	1.32	**1.20**
	PC-02 NTSV C-Section		28.8%	24.7%	24.0%	30.2%	27.0%	**23.9%**	26.6%	23.2%	**25.2%**
Efficient	Length of Stay O/E		1.19	1.16	1.22	1.19	1.19	**1.15**	1.19	1.22	**1.20**
	Median Time from ED Arrival to ED Departure (Enterprise)		174 min	167 min	168 min	164 min	168 min	**165 min**	157 min	154 min	**156 min**
Equitable	Homeless Discharge Clothing Documentation Compliance		----	----	----	----	----	**100.0%**	53.0% (184/347)	69.0% (240/348)	**61.0%** (424/695)
	Quality Council Health Equity Item Included in PI efforts (% of depts)		----	----	----	----	----	**50.0%**	0.0% (0/7)	33.3% (4/12)	**21.1%** (4/19)
	Sepsis Bundle Compliance by Race	Asian	----	----	----	----	----	**----**	77.8% (28/36)	75.0%* (12/16) (Oct-Nov)	**76.9%* (40/52) (July-Nov)**
	Sepsis Bundle Compliance by Race	Hispanic	----	----	----	----	----	**----**	93.3% (14/15)	81.3%* (13/16) (Oct-Nov)	**87.1%* (27/31) (July-Nov)**
	Sepsis Bundle Compliance by Race	White	----	----	----	----	----	**----**	86.6% (84/97)	82.8%* (53/64) (Oct-Nov)	**85.1%* (137/161) (July-Nov)**
	Sepsis Bundle Compliance by Race	Others	----	----	----	----	----	**----**	61.1% (11/18)	70.0%* (7/10) (Oct-Nov)	**64.3%* (18/28) (July-Nov)**
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend		79.9	78.8	76.6	78.4	78.5	**76.4**	84.0	80.3	**82.1**
	ED - Likelihood to Recommend (PG)		70.3	72.3	73.8	70.4	71.7	**71.7**	77.9	74.5	**76.2**
	MCH - HCAHPS Likelihood to Recommend		72.3	72.1	83.7	74.0	75.0	**75.0**	79.7	83.7	**81.5**

Updated: 01/23/24

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

Legend:

- **Green: At or exceeding target**
- **Yellow: Missed target by 5% or less**
- **Red: Missed target by > 5%**
- **White: No target**

El Camino Health

Quality Domain	Metric		Metric Definition
Safe Care	HAC Index 2.0 Score		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%.
	HAC Component: Cdiff Weighted (35%) Rate (per 10,000 Patient Days)		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.
	HAC Component: CAUTI Weighted (*15%*) Rate (per 1,000 Urinary Catheter Days)		1) Based on NHSN defined criteria 2) Exclusions : ED & OP
	HAC Component: CLABSI Weighted (15%) Rate (per 1,000 Central Line Days)		1) Based on NHSN defined criteria 2) Exclusions : ED & OP
	HAC Component: nvHAP Weighted (35%) Rate (per 1000 Patient Days)		≥ 3 days hospitalization & Not receiving mechanical ventilation. Evidence of order or procedure code for chest X-ray or computerized tomography of the chest. Administration of selected antimicrobials (e-Table 3) not previously administered in past 2 days and continued for ≥3 days (changes in antibiotics permitted during the 3 day period so long as each new agent was not used in the preceding 2 days). More detailed and specific definition can be provided.
	SSI Rate (per 100 surgical procedures) *(not part of HAC Index)*		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.
Timely	Lab STAT Troponin TAT for ED (received to verification)		A metric that assists with ED through-put and timely diagnosis of cardiac injury. The measurement begins with a time stamp of the specimen being received in the clinical laboratory and ends with a time stamp of the Troponin result being released to EPIC.
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)		Imaging TAT Criteria : TAT from Exam END to Exam Finalized, Routine orders only. Qualified exam won't include the exams that Prelim or ED Wet Read exists. On Target as defined as ED - <= 45 min. Over Target is defined as ED > 45 min. ED encounters
Effective	Risk Adjusted Readmissions Index		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.
	Risk Adjusted Mortality Index		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.
	Risk Adjusted Sepsis Mortality Index		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)
	PC-02 NTSV C-Section		1) Numerator: Patients with cesarean births 2) Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation
Efficient	Length of Stay O/E		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.
	Median Time from ED Arrival to ED Departure (Enterprise)		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
Equitable	Homeless Discharge Clothing Documentation Compliance		EMTALA - Homeless Discharge Navigator. Specifically for Clothing documented and compliance. Epic data source.
	Quality Council Health Equity Item Included in PI efforts (% of depts)		Departments that present a Health Equity (HE) -related item during Quality Council presentation / total departments presented
	Sepsis Bundle Compliance by Race	Asian	Sample of patients age >18 years, presenting in the Emergency Dept or In-patient unit with Severe Sepsis/Septic Shock (Suspected or known infection, 2+SIRS, 1 new organ dysfunction). Retrospective or concurrent chart reviews identified from one or more of the following: Emergency Room work up/differential, admitting diagnosis, Sepsis Alert, safety reporting system, EHR surveillance, iCare reporting, ICD-10 discharge code. Time of Presentation(TOP): time at which all criteria for severe sepsis are present, OR provider documentation of severe sepsis, whichever is earliest. Race is as defined of patient registration input, collected & documented in Epic.
	Sepsis Bundle Compliance by Race	Hispanic	
	Sepsis Bundle Compliance by Race	White	
	Sepsis Bundle Compliance by Race	Others	
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend		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'
	ED - Likelihood to Recommend (PG)		ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted'
	MCH - HCAHPS Likelihood to Recommend		Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted'

El Camino Health

HAC-A-Thon: C.diff

Look for the Green, Keep it Clean!

Look for the **GREEN** Contact Precautions sign for C.diff outside the patient's room and on the sanitizer station inside the room!

Infection Prevention

- The single most important way to prevent infection is **HANDWASHING!**
  - Remove PPE (gown/gloves) before handwashing upon exit
  - **Soap and water only**, wash for 40-60 seconds (no gel)
- Disinfect all surfaces and equipment
  - Use bleach (**orange top**) wipes to clean
- Use disposable equipment when applicable

Refer to Procedure: Management of C. diff Infection
For questions, contact Infection Prevention or Education Department

Prenatal Education | Maternal Child Health

Healthy Pregnancy for South Asian Families Class Series

A Virtual Four-Class Series designed for you and your family!

Join us to learn more about nutrition, exercise and preparing for birth. This series is designed as three classes to be taken over different stages of your pregnancy with a fourth class to be taken after your baby is born.

Learn from an experienced midwife and childbirth educator, a prenatal nutritionist, a labor and delivery nurse certified in prenatal exercise, and a certified lactation consultant in this series of classes as you progress through your pregnancy with us. The information is tailored to South Asian families but the classes are open to everyone.

- Class 1: Early 2nd trimester (~14-16 weeks)
- Class 2: Late 2nd trimester (~24-26 weeks)
- Class 3: Early 3rd trimester (~34-36 weeks-
- Class 4: Postpartum (~4-6 weeks after delivery)

Sign up for the four-class series via Course Storm:
https://elcaminohealth.coursestorm.com/category/maternal-child-education

4 Class Series Cost: $100/family

El Camino Health®

Mother-Baby Health
2500 Grant Road | Mountain View, CA 94040 | 650-940-7000
815 Pollard Road | Los Gatos, CA 95032 | 408-378-6131
elcaminohealth.org/maternity

El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: El Camino Hospital Board Quality, Patient Care and Patient Experience Committee ("ECHB Quality Committee")
From: Ute Burness, RN, VP of Quality, and Shahab Dadjou, President, ECHMN
Date: February 5, 2024
Subject: ECHMN Quarterly Quality Report

Purpose:

Provide the ECHB Quality Committee with a quarterly update on the status of quality of care within the El Camino Health Medical Network (ECHMN).

Summary:

1. Situation: Silicon Valley Medical Development (SVMD) is a separate limited liability corporation (LLC) formed in 2008 for the purposes of, among other things, developing and maintaining ambulatory ventures, establishing initiatives between independent physicians and El Camino Hospital, and establishing and providing management services to medical groups. This ambulatory and physician network is generally referred to as ECHMN. El Camino Hospital is the sole corporate member of the LLC. Pursuant to the Second and Amended Restated Limited Liability Company Operating Agreement for the LLC dated November 18, 2019 ("Operating Agreement"), SVMD is required to report to the ECHB Quality Committee on a quarterly basis. The Operating Agreement does not specify requirements for the reports, thus deferring to SVMD's managers to provide appropriate information.

2. Authority: The ECHB Quality Committee is tasked with advising the ECHB and to monitor and support the quality and safety of care provided at El Camino Hospital. Governing authority for SVMD resides with the SVMD Board of Managers. However, the overall quality of ECHMN is an area of interest for the ECHB Quality Committee as the quality of care provided by ECHMN may directly and indirectly impact the quality of the care delivered to El Camino Hospital patients.

3. Background: SVMD was established to develop an ambulatory care capability so that the El Camino Health continuum of care could extend beyond the traditional hospital acute care and hospital-based outpatient care.

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

A. Clinical Excellence,
B. Dependable and Convenient Care
C. Patient Experience (Likelihood to Recommend (LTR)

ECHMN has established true north pillars, one of which is quality and service. Starting June 1, 2023, ECHMN changed its quality reporting methodology to calendar year to better align with the Centers for Medicare and Medicaid (CMS) and major health plans/payers. For calendar year 2023, ECHMN has met/exceeded targets in all eight (8) quality metrics. The Network is performing in the 9th and 10th decile in 5 measures with

plans to improve other core measures from their current 7th and 8th decile. Year over year, there is a consistent pattern of improvement in each of the eight (8) measures since 2021.

For the dependable and convenient domain, third next available (3NA) remains unfavorable for primary care and specialty care. The clinical response to patient messages did not meet target. Improvement plans have been presented to the Board of Managers which describe the approach and timetable to meet expectations for access and message response by the end of FY2024. The attached slide deck describes the improvement plan that is in place.

Likelihood to Recommend (LTR) is on target for Primary Care, Specialty and Urgent Care.

List of Attachments:

PowerPoint 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 ECHB Quality Committee to receive in the quarterly reports from ECHMN?

El Camino Health

ECH Quality Committee Meeting
ECHMN Quality Update

February 5, 2024

Ute Burness, RN, Vice President of Quality ECHMN
Shahab Dadjou, President ECHMN

Agenda

- **Clinical Domain**
  - Calendar Year 2023 YTD Results
- **Dependable and Convenient Domain**
  - FY 2024 2nd Quarter Results
- **Patient Experience Domain**
  - FY 2024 2nd Quarter Results

Clinical Domain

Core Quality Measures Results as of CY ending 1/2/24

Core Measures	CY 2023 Goal	Current Results	2023 CMS Decile of Current Results	% Needed to be in 10th Decile
	7 of 8	8 of 8		
CMS 112 Breast Cancer Screening	78%	79%	9th	>=82.05%
CMS 122 Diabetes: Hemoglobin A1c poor control>9% *(lower number is better)*	17%	15%	10th	</=17.07%
CMS 130 Colorectal Cancer Screening	68%	73%	8th	>=85.69%
CMS 138 Tobacco - Screening and Cessation Intervention Plan	85%	96%	9th	>/=98.33
CMS 139 Fall Risk Screening	98%	99%	10th	>=98.92%
CMS 165 Controlling High Blood Pressure	72%	75%	8th	>=81.35%
CMS 347 Statin Therapy for ACSVD Patients	86%	86%	10th	>=84.75%
CMS 68 Reconciliation of Current Medications	98%	98%	7th	>=99.87%

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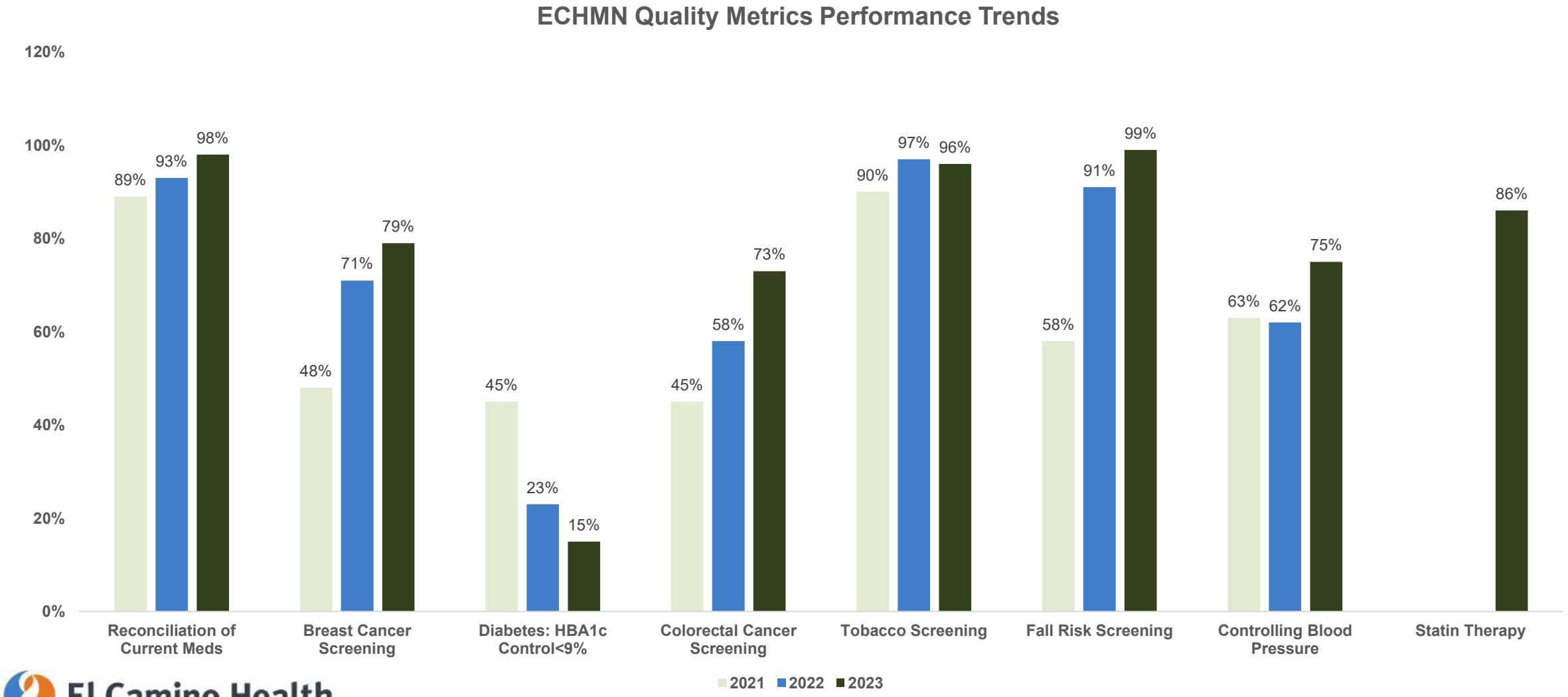
Core Quality Measures Year Over Year Trend

2023 was another strong year for ECHMN Quality, with performance increases from 2022 in 5 of 6 selected metrics and 2023 targets met in 8 of the 8



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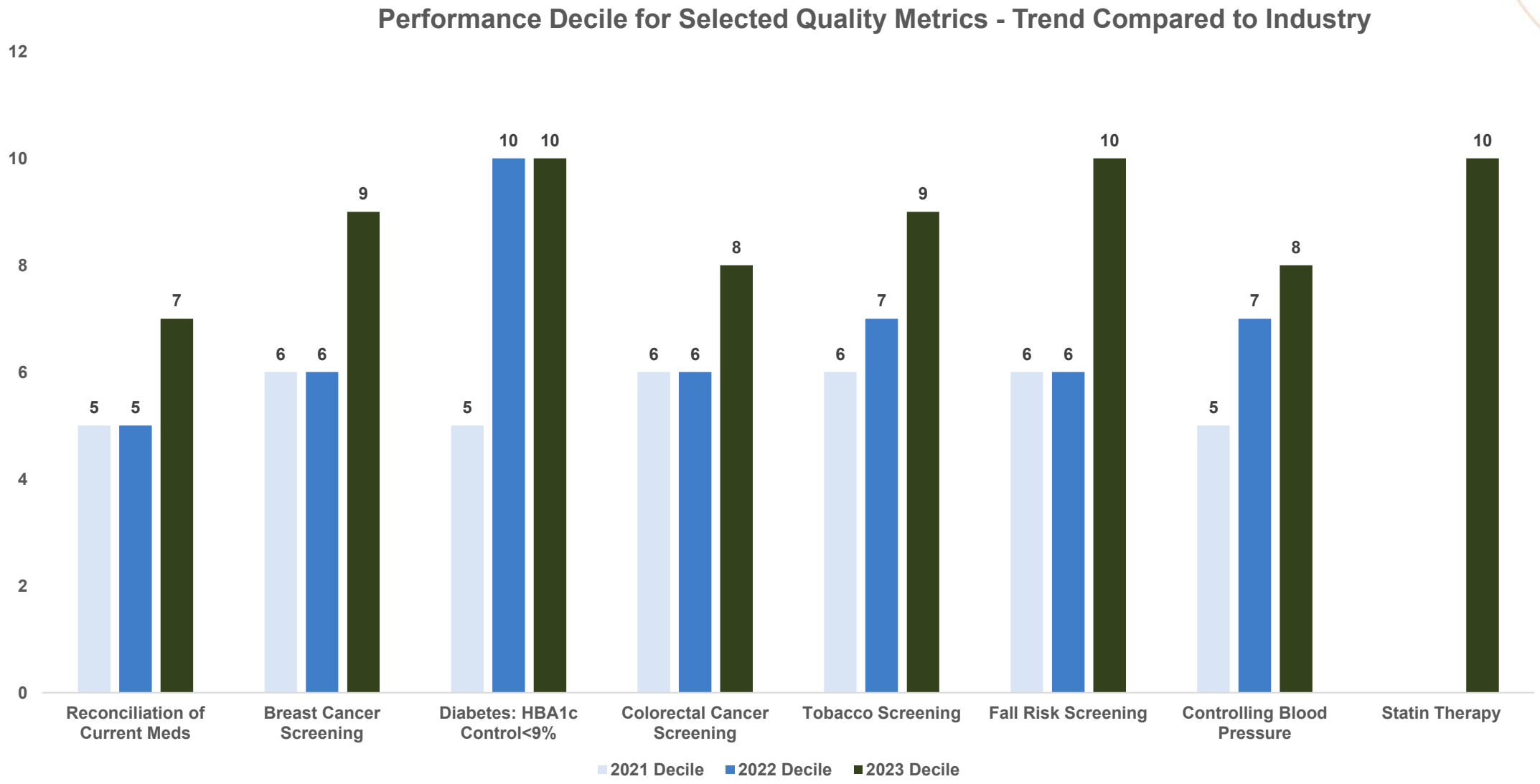
Quality Metric Performance by Deciles Year over Year Trend



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*The deciles utilized are the published by Centers for Medicare and Medical (CMS)on an annual basis

FYTD Accomplishments

- Received credentialing re-delegation for all health plan with a score of 100%
- 83 Providers went through initial credentialing
- 49 Providers went through re-credentialing
- 30 Providers separated from the organization (*9-ECHMN, 16- Contracted, 1-IPA and 4 –Downstream providers)*
- Reviewed and updated the credentialing policies and procedures
- Reviewed and updated the quality policies and procedures
- Submitted our first Medicare Value Pathway (MVP) for calendar year 2023
- Achieved 7 of 8 quality measures
- Developed and implemented emergency flow sheets for the urgent care centers
- Developed and implemented a “Hand Hygiene” campaign for the clinics
- Developed and implemented “Mock Code” drills for the urgent care centers
- Developed and implemented “Medical Emergency’ and “Fall Risk” protocols for the urgent care centers

Dependable and Convenient Care Results

Dependable, Convenient and Experience Domain – FY 2024

Results as of

Domain	Measure	Baseline FY23	FY24 Target	FYTD 24
Dependable and Convenient	Access 3na for Primary Care by Department (in days) (Access Third Next Available – Lower is better)	7.5	7.0	9.1
	Access 3na for Specialty Care by Provider (in days) (Access Third Next Available – Lower is better)	23.6	22	35.7
	Clinician Response to Patient Messages < 48 hours (in days)	1.6	1.2	1.6
Experience	Primary Care and Specialty LTR (Likelihood to Recommend)	80.7	81.3	**82.1**
	Urgent Care LTR (Likelihood to Recommend)	76.1	78.0	**78.5**

Met Target
Missed Target by < 5%
Missed Target by > 5%

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Dependable, Convenient Domain – Improvement Plan

Measure	Results	Contributing Factors	Action Plan
Primary Care 3rd Next Available (3NA)	9.1 Days	• Concentrated time off in November and December, due to holiday time out of office • Loss of two PCPs and two APCs October - December	• Five PCPs hired September – October; two APCs hired October • Continue to recruit PCPs and APCs • Shift certain appointments to APCs
Specialty Care 3rd Next Available (3NA)	35.7 Days	• Two PA-Cs hired in two specialties (GI, Ortho Spine) • Concentrated time off in November and December, due to holiday time out of office	• Continue to recruit specialists and APCs • Increased specialties enabled for automated wait list scheduling • Improve quality of referrals sent to specialists with more education on appropriate work up • Longer term plan to expand referrals to IPA/Downstream providers with visibility to their soonest available appointments
Clinician Response Time for Messages	1.6 Days	• Refill request workflow inflates the average turnaround time	• Refill request workflow is being changed and provider education is being delivered once the change is finalized • Education for providers that weekends are included in this metric • Continue to recruit three primary care RNs for advice requests and triage needs

Patient Experience Domain – Results FY2024

ENTERPRISE	FY23 (Baseline)	FY24 Target Goals	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23		FYTD	Gap to Baseline	Gap to Target
***ECHMN - All**	**80.7**	**81.3**	**82.2**	**82.5**	**79.4**	**82.9**	**82.4**	**83.4**		**82.1**	**1.4**	**0.8**
Primary Care & Specialty Care	27	32	34	35	21	37	32	38		30		
	10017	-	1286	826	703	697	545	458		4516		
ECHMN - Primary Care	**79.6**	**80.1**	**80.6**	**81.6**	**77.6**	**81.3**	**77.4**	**77.7**		**79.7**	**0.1**	**-0.4**
with Pediatrics	22	26	26	30	15	28	14	14		19		
	5720	-	612	396	304	336	292	238		2178		
ECHMN - Specialty Care	**82.2**	**82.6**	**83.7**	**83.3**	**80.7**	**84.5**	**88.2**	**89.6**		**84.3**	**2.1**	**1.7**
	34	39	44	43	26	47	77	88		43		
	4297	-	674	430	399	361	254	220		2338		
ECHMN - Urgent Care	**76.1**	**78.0**	**77.2**	**77.6**	**73.8**	**80.0**	**83.3**	**77.5**		**78.5**	**2.4**	**0.5**
	36	68	36	37	19	53	74	48		53		
	1323	-	158	156	107	140	162	178		901		
All Clinics LTR Clinic Top Box e-survey adjusted - Indicates Incentive Goal*												
Data as of 1/2/24												

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Questions?

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EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

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Summary:

1. Situation: Silicon Valley Medical Development (SVMD) is a separate limited liability corporation (LLC) formed in 2008 for the purposes of, among other things, developing and maintaining ambulatory ventures, establishing initiatives between independent physicians and El Camino Hospital, and establishing and providing management services to medical groups. This ambulatory and physician network is generally referred to as ECHMN. El Camino Hospital is the sole corporate member of the LLC. Pursuant to the Second and Amended Restated Limited Liability Company Operating Agreement for the LLC dated November 18, 2019 ("Operating Agreement"), SVMD is required to report to the ECHB Quality Committee on a quarterly basis. The Operating Agreement does not specify requirements for the reports, thus deferring to SVMD's managers to provide appropriate information.

2. Authority: The ECHB Quality Committee is tasked with advising the ECHB and to monitor and support the quality and safety of care provided at El Camino Hospital. Governing authority for SVMD resides with the SVMD Board of Managers. However, the overall quality of ECHMN is an area of interest for the ECHB Quality Committee as the quality of care provided by ECHMN may directly and indirectly impact the quality of the care delivered to El Camino Hospital patients.

3. Background: SVMD was established to develop an ambulatory care capability so that the El Camino Health continuum of care could extend beyond the traditional hospital acute care and hospital-based outpatient care.

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

A. Clinical Excellence,
B. Dependable and Convenient Care
C. Patient Experience (Likelihood to Recommend (LTR)

ECHMN has established true north pillars, one of which is quality and service. Starting June 1, 2023, ECHMN changed its quality reporting methodology to calendar year to better align with the Centers for Medicare and Medicaid (CMS) and major health plans/payers. For calendar year 2023, ECHMN has met/exceeded targets in all eight (8) quality metrics. The Network is performing in the 9th and 10th decile in 5 measures with

plans to improve other core measures from their current 7th and 8th decile. Year over year, there is a consistent pattern of improvement in each of the eight (8) measures since 2021.

For the dependable and convenient domain, third next available (3NA) remains unfavorable for primary care and specialty care. The clinical response to patient messages did not meet target. Improvement plans have been presented to the Board of Managers which describe the approach and timetable to meet expectations for access and message response by the end of FY2024. The attached slide deck describes the improvement plan that is in place.

Likelihood to Recommend (LTR) is on target for Primary Care, Specialty and Urgent Care.

List of Attachments:

PowerPoint 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 ECHB Quality Committee to receive in the quarterly reports from ECHMN?

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ECH Quality Committee Meeting
ECHMN Quality Update

February 5, 2024

Ute Burness, RN, Vice President of Quality ECHMN
Shahab Dadjou, President ECHMN

Agenda

- **Clinical Domain**
  - Calendar Year 2023 YTD Results

- **Dependable and Convenient Domain**
  - FY 2024 2nd Quarter Results

- **Patient Experience Domain**
  - FY 2024 2nd Quarter Results

Clinical Domain

Core Quality Measures Results as of CY ending 1/2/24

Core Measures	CY 2023 Goal	Current Results	2023 CMS Decile of Current Results	% Needed to be in 10th Decile
	7 of 8	8 of 8		
CMS 112 Breast Cancer Screening	78%	79%	9th	>=82.05%
CMS 122 Diabetes: Hemoglobin A1c poor control>9% *(lower number is better)*	17%	15%	10th	</=17.07%
CMS 130 Colorectal Cancer Screening	68%	73%	8th	>=85.69%
CMS 138 Tobacco - Screening and Cessation Intervention Plan	85%	96%	9th	>/=98.33
CMS 139 Fall Risk Screening	98%	99%	10th	>=98.92%
CMS 165 Controlling High Blood Pressure	72%	75%	8th	>=81.35%
CMS 347 Statin Therapy for ACSVD Patients	86%	86%	10th	>=84.75%
CMS 68 Reconciliation of Current Medications	98%	98%	7th	>=99.87%

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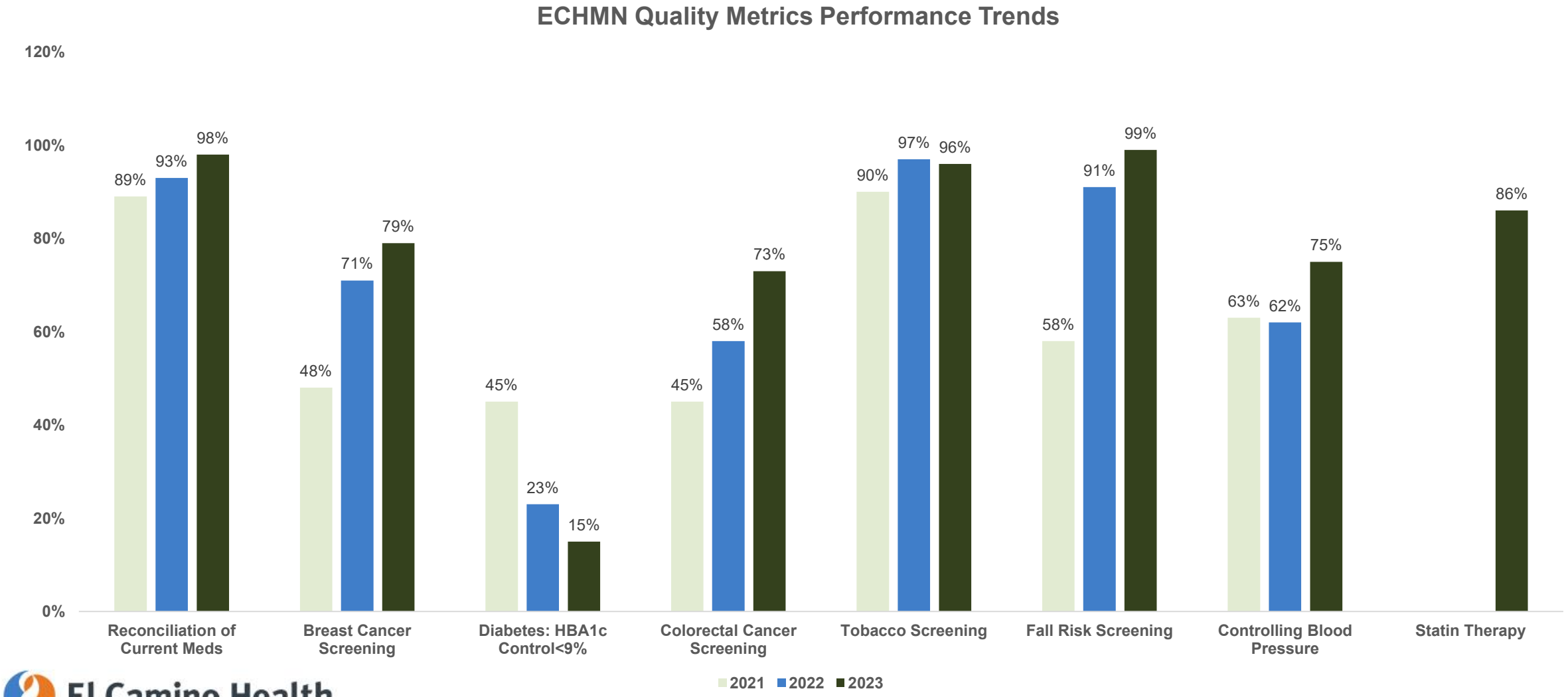
Core Quality Measures Year Over Year Trend

2023 was another strong year for ECHMN Quality, with performance increases from 2022 in 5 of 6 selected metrics and 2023 targets met in 8 of the 8



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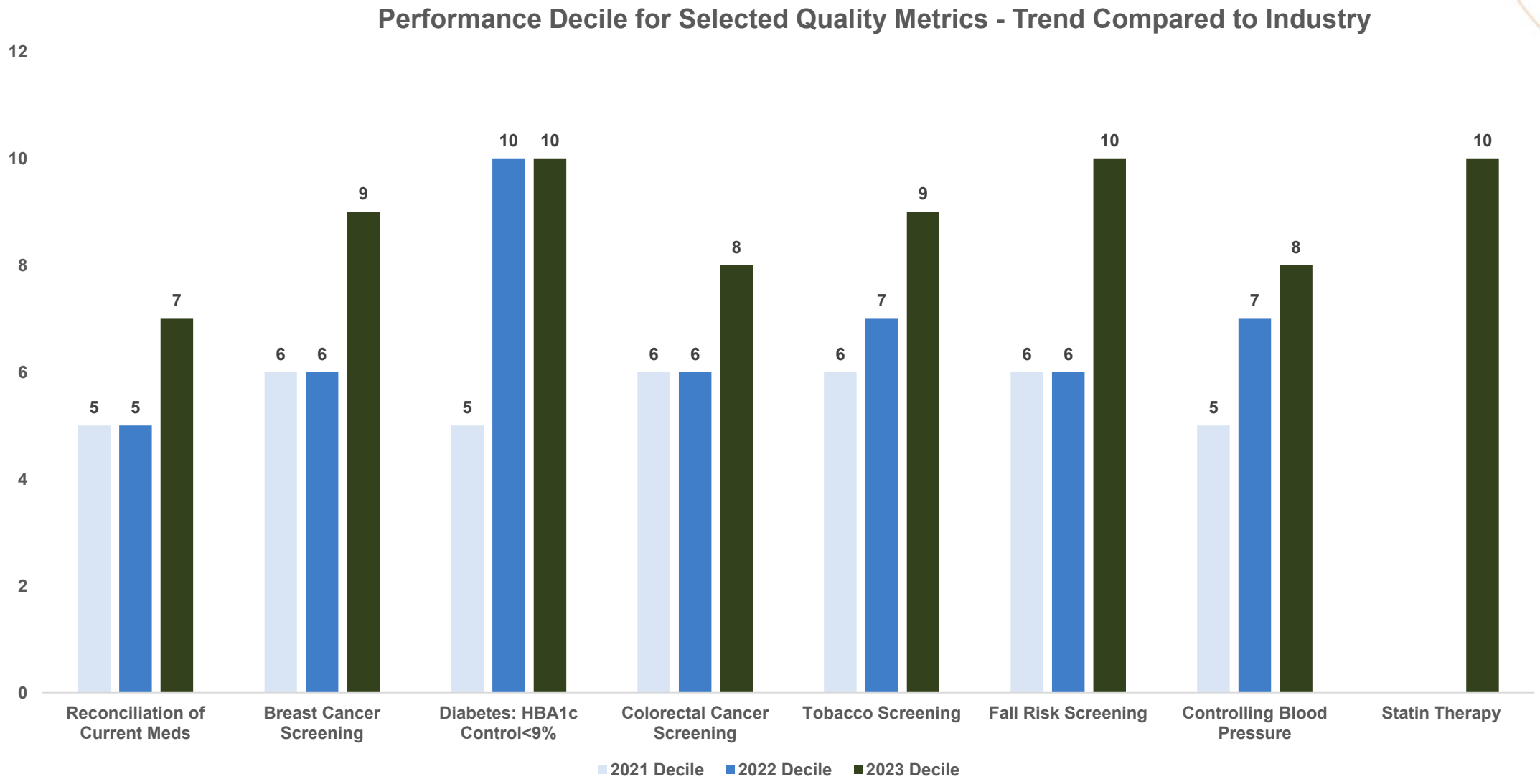
Quality Metric Performance by Deciles Year over Year Trend



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*The deciles utilized are the published by Centers for Medicare and Medical (CMS)on an annual basis

FYTD Accomplishments

- Received credentialing re-delegation for all health plan with a score of 100%
- 83 Providers went through initial credentialing
- 49 Providers went through re-credentialing
- 30 Providers separated from the organization (*9-ECHMN, 16- Contracted, 1-IPA and 4 –Downstream providers)*
- Reviewed and updated the credentialing policies and procedures
- Reviewed and updated the quality policies and procedures
- Submitted our first Medicare Value Pathway (MVP) for calendar year 2023
- Achieved 7 of 8 quality measures
- Developed and implemented emergency flow sheets for the urgent care centers
- Developed and implemented a “Hand Hygiene” campaign for the clinics
- Developed and implemented “Mock Code” drills for the urgent care centers
- Developed and implemented “Medical Emergency’ and “Fall Risk” protocols for the urgent care centers

Dependable and Convenient Care Results

Dependable, Convenient and Experience Domain – FY 2024

Results as of

Domain	Measure	Baseline FY23	FY24 Target	FYTD 24
Dependable and Convenient	Access 3na for Primary Care by Department (in days) (Access Third Next Available – Lower is better)	7.5	7.0	9.1
	Access 3na for Specialty Care by Provider (in days) (Access Third Next Available – Lower is better)	23.6	22	35.7
	Clinician Response to Patient Messages < 48 hours (in days)	1.6	1.2	1.6
Experience	Primary Care and Specialty LTR (Likelihood to Recommend)	80.7	81.3	**82.1**
	Urgent Care LTR (Likelihood to Recommend)	76.1	78.0	**78.5**

Met Target
Missed Target by < 5%
Missed Target by > 5%

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Dependable, Convenient Domain – Improvement Plan

Measure	Results	Contributing Factors	Action Plan
Primary Care 3rd Next Available (3NA)	9.1 Days	• Concentrated time off in November and December, due to holiday time out of office • Loss of two PCPs and two APCs October - December	• Five PCPs hired September – October; two APCs hired October • Continue to recruit PCPs and APCs • Shift certain appointments to APCs
Specialty Care 3rd Next Available (3NA)	35.7 Days	• Two PA-Cs hired in two specialties (GI, Ortho Spine) • Concentrated time off in November and December, due to holiday time out of office	• Continue to recruit specialists and APCs • Increased specialties enabled for automated wait list scheduling • Improve quality of referrals sent to specialists with more education on appropriate work up • Longer term plan to expand referrals to IPA/Downstream providers with visibility to their soonest available appointments
Clinician Response Time for Messages	1.6 Days	• Refill request workflow inflates the average turnaround time	• Refill request workflow is being changed and provider education is being delivered once the change is finalized • Education for providers that weekends are included in this metric • Continue to recruit three primary care RNs for advice requests and triage needs

Patient Experience Domain – Results FY2024

ENTERPRISE	FY23 (Baseline)	FY24 Target Goals	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23		FYTD	Gap to Baseline	Gap to Target
***ECHMN - All**	**80.7**	**81.3**	**82.2**	**82.5**	**79.4**	**82.9**	**82.4**	**83.4**		**82.1**	**1.4**	**0.8**
Primary Care & Specialty Care	27	32	34	35	21	37	32	38		30		
	10017	-	1286	826	703	697	545	458		4516		
ECHMN - Primary Care	**79.6**	**80.1**	**80.6**	**81.6**	**77.6**	**81.3**	**77.4**	**77.7**		**79.7**	**0.1**	**-0.4**
with Pediatrics	22	26	26	30	15	28	14	14		19		
	5720	-	612	396	304	336	292	238		2178		
ECHMN - Specialty Care	**82.2**	**82.6**	**83.7**	**83.3**	**80.7**	**84.5**	**88.2**	**89.6**		**84.3**	**2.1**	**1.7**
	34	39	44	43	26	47	77	88		43		
	4297	-	674	430	399	361	254	220		2338		
ECHMN - Urgent Care	**76.1**	**78.0**	**77.2**	**77.6**	**73.8**	**80.0**	**83.3**	**77.5**		**78.5**	**2.4**	**0.5**
	36	68	36	37	19	53	74	48		53		
	1323	-	158	156	107	140	162	178		901		
All Clinics LTR Clinic Top Box e-survey adjusted - Indicates Incentive Goal*												
Data as of 1/2/24												

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Questions?

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