El Camino Health

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

Monday, August 7, 2023 – 5:30 pm
El Camino Health | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

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

1-669-900-9128, MEETING CODE: 944 6945 5985#. No participant code. Just press #.

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Carol Somersille, MD Quality Committee Chair		**5:30 – 5:32 pm**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Carol Somersille, MD Quality Committee Chair	*public comment*	**possible motion 5:32 – 5:33**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair		**information 5:33 – 5:34**
4.	**PUBLIC COMMUNICATION**	Carol Somersille, MD Quality Committee Chair		**information 5:34 – 5:37**
5.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Quality Committee Meeting (06/05/2023) ***Information*** b. FY24 Pacing Plan c. QC Follow-Up Items	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 5:37 – 5:47**
6.	**CHAIR'S REPORT**	Carol Somersille, MD Quality Committee Chair		**information 5:47 – 5:52**
7.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer		**discussion 5:52 – 6:02**
8.	**Q4 FY23 STEEEP DASHBOARD & FY23 ENTERPRISE QUALITY DASHBOARD**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:02 – 6:27**

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
9.	**EL CAMINO HEALTH MEDICAL NETWORK REPORT**	Shahab Dadjou, President, El Camino Health Medical Network Ute Burness, VP of Quality and Payer Relations		**discussion 6:27 – 6:52**
10.	**ADJOURN TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 6:52 – 6:53**
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair		**information 6:53 – 6:54**
12.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (06/05/2023) ***Information*** *Health and Safety Code Section 32155* b. Quality Council Minutes (06/07/2023)	Carol Somersille, MD Quality Committee Chair		**motion required 6:54 – 6:59**
13.	*Health and Safety Code Section 32155* **Q4 FY23 QUARTERLY QUALITY AND SAFETY REVIEW OF REPORTABLE EVENTS**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:59 – 7:09**
14.	*Health and Safety Code Section 32155* **CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer		**motion required 7:09 – 7:19**
15.	*Health and Safety Code Section 32155* **SERIOUS SAFETY/RED ALERT EVENT**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 7:19 – 7:24**
16.	**ADJOURN TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair		**motion required 7:24 - 7:25**
17.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair		**information 7:25 – 7:26**
18.	**ROUNDTABLE**	Carol Somersille, MD Quality Committee Chair		**discussion 7:26 – 7:29**
19.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 7:29 – 7:30 pm**

Next Meeting: September 5, 2023, November 6, 2023, December 4, 2023, February 5, 2024, 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, June 5, 2023
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Carol Somersille, MD
Prithvi Legha, MD
Jack Po, MD
Krutica Sharma, MD
Melora Simon**
John Zoglin

Members Absent
Pancho Chang
Philip Ho, MD

Others Present
Holly Beeman, MD, MBA, CQO
Dan Woods, CEO**
Mark Adams, MD, CMO
Deb Muro, CIO**
Cheryl Reinking, DPN, RN, CNO
Shreyas Mallur, MD, ACMO
Lyn Garrett, Senior Director, Quality
Daniel Shih, MD
Tracy Fowler, Director, Governance Services
Nicole Hartley, Executive Assistant II

**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 5:34 pm by Chair Carol Somersille. A verbal roll call was taken. Dr. Po joined at 5:45 pm. Mr. Chang and Dr. Ho were absent. All other members were present at roll call and participated in person or telephonically. A quorum was present.	
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	Ms. Hartley shared that we have one member of the Committee, Melora Simon participating remotely due to Just Cause. Chair Somersille ask Ms. Simon if there were any adults in the room. Ms. Simon confirmed there were not.	
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. Mr. Zoglin pulled items 5d – FY23 Enterprise Quality Dashboard and 5g – Quality Committee Survey Results. Dr. Sharma pulled item 5d – FY23 Enterprise Quality Dashboard. Mr. Zoglin asked on page 12 of 5d - FY23 Enterprise Quality Dashboard, how we define and measure "home with home health". Dr. Beeman shared that prior to discharge, we arrange to have a home health agency come to the patient's house. This requires a doctor's order (to ensure the home health agency is paid). Our ECH Care Coordination team facilitates identification and disposition to various partner home health agencies. Mr. Zoglin asked about Good Samaritan closing their in-patient psychiatry. Do we have any insight on why they closed it? Dr. Beeman responded that when Good Sam announced it, they stated they could not get enough staff to staff it. Dr. Legha asked if we have had an increase in our in-patient psychiatric department. Cheryl Reinking, CNO responded that we are full every day. During COVID, they had to limit and cap our census but now we are at 36 patients every day. Dr. Sharma asked about patient fall rates and how our target compares to the epidemiologic average and how does this break down by falls with harm. Dr. Beeman responded by sharing the definition of the measure and that falls with harm are included in the total but the report does not break it down. Management does have reporting about the falls with harm. Dr. Sharma asked what our percentage is for falls with harm. Dr. Beeman shared she will bring this information to the next meeting as a follow-up item. Chair Somersille requested that for 5a – Minutes of the Open Session of the Quality Committee Meeting (05/01/2023), we add Mr. Zoglin's comments regarding the top box 5 scores. The language added was as follows: *The committee also deliberated on the importance of incorporating data regarding scores of 4s and 5s. Director Zoglin emphasized the significance of prioritizing the top box scores, as these individuals have the potential to become advocates.* Ms. Simon followed up on 5f – QC Follow Up items, asked about the ED deep dive, and could not recall it being discussed. Dr. Beeman shared that a detailed description of the improvement work to reduce ED throughput was included in the Quality Dashboard memo in the May 2023 Quality Committee meeting. Ms. Simon asked if there was discussion about this. Dr. Beeman said, no, there were no questions and that this surprised her as she specifically requested Dr. Bhimani attend the meeting in person to field any questions	***Consent Calendar Approved*** ***Follow Up****: Dr. Beeman to share Patient Falls rate with harm percentage at next meeting*

	from the committee members about the ED Throughput performance. Mr. Zoglin asked about 5g – Quality Committee Survey Results, and what our next steps are for this information. Ms. Fowler responded that these survey results provide a baseline so that for future surveys, improvement or deterioration can be measured. The results identified themes: Committee members desire more time be spent discussing patient experience and there is a disconnect between how committee members and staff view the 'performance' of the committee and its members and staff. Ms. Simon asked if we could set aside time to discuss the results as a Committee. Chair Somersille responded yes. An idea presented was to have an educational session regarding the results. **Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (05/01/2023), For information: (b) Report on Board Actions, (c) Progress against FY2023 Committee Goals, (d) FY23 Enterprise Quality Dashboard, (e) Leapfrog, (f) QC Follow-Up Items, (g) Quality Committee Survey Results **Movant**: Sharma **Second**: Zoglin **Ayes**: Somersille, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Chang, Ho **Recused**: None	
6. CHAIR'S REPORT	Chair Somersille thanked the Committee members for all of their time and hard work this year. Chair Somersille noted that the committee and staff partnership has positively progressed and that the intentions of both the Committee and the staff stems from dedication to make the hospital the best it can be.	
7. PATIENT STORY	Cheryl Reinking, CNO presented a patient story received by Press Ganey from a patient who recently had a baby at El Camino Health in Mountain View. The feedback shared was that the chair beds were nice but still uncomfortable for her husband. Cheryl shared pictures of the new beds with the committee that would be in the newly built NICU and mother baby unit. The target date to move into the new NICU unit is August 21st. Chair Somersille asked if the Committee would get a tour of the new Maternal Child Health building. Ms. Fowler shared that a tour will be scheduled for the Hospital Board and an invitation will be extended to the Committees. The Committee asked questions about upgrades in other areas of the hospital and Cheryl provided information around past	

	upgrades that have been completed and room sizes that could potentially fit this new type of chair bed.	
8. HEALTH CARE EQUITY	Dr. Holly Beeman, CQO presented on Health Care Equity and highlighted the following: • Health Equity definition and why this is being focused on now • Visual example of inequality, equality, equity, and justice • Current challenges and examples of each challenge: data definitions, bias, and scope • ECH race ethnicity data collection • Health disparities driven by social and economic inequities • Details about ECH's Health Equity Department's initial priorities: 1. Data integrity and accuracy 2. Homelessness 3. Quality Council Reboot 4. Segregating our ECH sepsis bundle compliance by race and ethnicity Mr. Zoglin asked how do we look at social impediments to healthcare – is race or finance the biggest impact? Dr. Beeman responded that one term that describes this best is intersectionality. The focus should be geared more towards if there is anything in our control to provide resources or care differently, to ensure that each patient has Care which is uniquely designed to address their specific needs. Dr. Legha shared that outcomes can and often are expected to be different. Ensuring the care is tailored specifically to the unique needs of the patient to maximize their chance at an optimal outcome is the focus. It is OK that care provided varies, as long as the variation is desirable and advantageous. Dr. Sharma stated how we need to ask the sexual orientation and gender identity early and consistently. This could directly impact LTR scores. Ms. Simon shared her experience with implementing CalAIM and the resources available for people experiencing homelessness. Ms. Simon also offered to share her expertise with this Committee about the resources that are newly available. Dr. Beeman discussed how the team selected homelessness as a starting place as ECH was cited by CMS for failing to follow our own policy on discharge and care of homeless patients. As part of the corrective action plan, we are auditing the reliability with which we accurately identify which of our patients are homeless. Ms. Simon advised that the first stage could be doing a robust health related social needs screening. Ms. Simon touched on the resources available including	

	PRAPARE and potentially piloting this screening tool to help drive our focus to where is needed. Dr. Po asked if we are wanting to be in work groups focused on improving data accuracy in healthcare systems, such as those led by Epic or CMS community groups if deemed beneficial after careful consideration. Dr. Beeman responded that it is a great question and that we are still deciding whether we want to be part of creating/influencing this or a consumer of this. Ms. Simon recommended reaching out to public hospitals like Valley Medical or San Mateo Medical or Highland for perspective and potential collaboration on addressing issues related to cultural and linguistic diversity among first-generation immigrants at El Camino Hospital. Dr. Shin shared that language disparity is a problem at our hospital and shared examples he has experienced when caring for patients who do not speak English. Dr. Legha concurred and shared that the amount of time spent in discussion with patients who don't speak English is shorter than with those who do, even with the use of the language translation services. Discussion occurred. A few ideas to address this disparity are to investigate the possibility of providing every non-native English speaker with an iPad for translating in their hospital room, implement a system to make language preferences more visible, i.e. potentially using signs or boards so that staff can be fully equipped, and research acquiring additional funding for more iPads through VOYCE. There was extensive discussion regarding health equity and the importance of this work.	
9. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPI)	Dr. Holly Beeman, CQO presented the Quality Assessment and Performance Improvement Plan and highlighted the following: • Quality Assurance and Performance Improvement Governance Information Flow FY23 Dr. Sharma ask about having the Quality Committee defined or mentioned in the QAPI plan since this Committee is a delegated authority of the Hospital Board. Dr. Beeman confirmed that is good feedback and will add the language. Ms. Simon asked if in the future, can a redline version and a final version be shared with the Committee. Dr. Beeman shared that there were a substantial amount of changes made this year, which could make it difficult to read. Going forward, it should not be an issue to share the redline version and a clean version and will do so in FY2024. **Motion**: To recommend the Quality Assessment and Performance Improvement Plan for Board Approval - provided language is updated to reflect Dr. Sharma's recommendation.	***Quality Assessment and Performance Improvement Plan Approved*** ***Follow Up****: Dr. Beeman to add language reflecting the Quality Committee in the QAPI plan*

	Movant: Zoglin **Second**: Sharma **Ayes**: Somersille, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Chang, Ho **Recused**: None	
10. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 7:10 pm. **Movant**: Po **Second**: Sharma **Ayes**: Somersille, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Chang, Ho **Recused**: None	***Adjourned to closed session at 7:10 pm***
11. AGENDA ITEM 16: RECONVENE OPEN SESSION/REPORT OUT	The open session reconvened at 7:22 pm. Agenda items 11-15 were addressed in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (05/01/2023), the Quality Council Minutes (05/03/2023), and the Credentialing and Privileges Report by unanimous vote by all committee members present.	
12. AGENDA ITEM 17: ROUNDTABLE	No comments were shared.	
13. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 7:23 pm **Movant**: Po **Second**: Legha **Ayes**: Somersille, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Chang, Ho **Recused**: None	***Adjourned at 7:23 pm***

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

_____

Nicole Hartley, Executive Assistant, II

Prepared by: Nicole Hartley, Executive Assistant, II
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		~~✓~~	✓									
Special Topic (Placeholder)			~~✓~~								✓	
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)

4/4/2023

As of: 6/06/23

Quality Committee Follow-Up Items

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

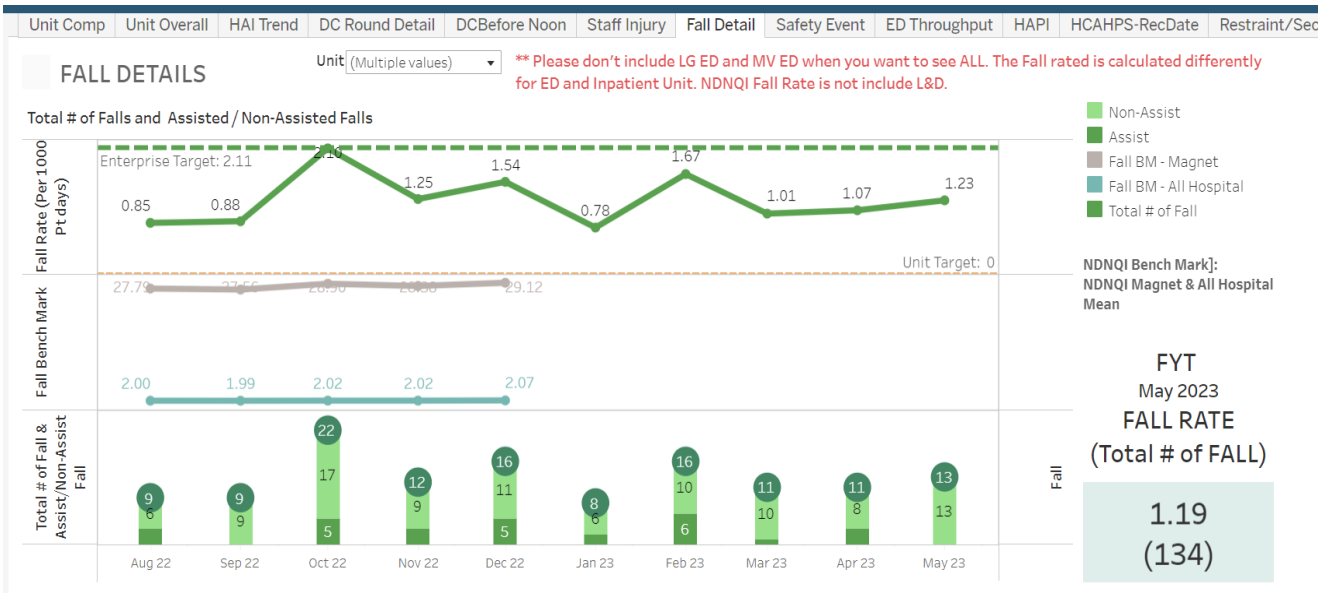
El Camino Health

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

To: Quality, Patient Care and Patient Experience Committee
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: August 7, 2023
Subject: Quality Committee Follow Up Item: Fall Rate

Background: During the June 5, 2023 Board Quality Safety and Experience Committee, Dr. Beeman shared update on performance for reducing patient falls. Dr. Sharma asked for information on the rate of patient falls. The number of falls is reported on the dashboard, not the rate of falls.

A screenshot of our FALLS Dashboard is displayed below. The rate excludes falls, which occur on labor and delivery and the ED in concordance with measure definition criteria established by NDNQI (National Database of Nursing Quality Indicators).



El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP, RN, NEA-BC, DipACLM
Date: August 7, 2023
Subject: Patient Experience feedback from Employee Report

Purpose: To provide the Committee with written patient feedback that is received from an employee that affected a family member's experience at El Camino Health.

Summary:

1. Situation: These comments are from an employee who was reporting a concern with the language translation device used at El Camino.

2. Authority: To provide insight into the need for a reliable language translation service for our patients and their families

3. Background: A patient drove himself at 1am to the ED and had quickly been evaluated for an AMI and was rushed to the Cardiac Cath lab for PCI. Unfortunately, the patient was in full cardiac arrest before the procedure started and the staff were not able to revive him. In situations like this, staff take the patient to a patient care area that is outside the procedural area so families can come in and say goodbye as happened in this situation. The wife of the patient was called and we were able to communicate she should come to the hospital immediately. When she arrived, we learned she spoke little English. Japanese was her primary language. The wife was guided to the nursing unit and staff attempted to call the language translation line and were unsuccessful in reaching a Japanese interpreter. This was very frustrating for the staff as well as very distressing for the wife. Thankfully, the staff were able to reach the daughter in Japan who was able to translate.

4. Assessment: As discussed at this meeting in the past, having a reliable and available language translation tool is imperative in delivering care to our patients and families. The company who provides our language translation service did not meet our needs in this situation and a meeting has occurred with the CEO and COO indicating the seriousness of this event and the service standards we expect them to uphold. We have also spoken to the staff and provided follow up regarding the actions we have taken to assure the language translation service is available and the importance of reporting future problems.

5. Other Reviews: None

6. Outcomes: As discussed at a previous meeting, not only we will assure our language translations service is available, but stationed in each room. We plan to start with a pilot in 3C where we will place a ipad with the translation service in every room in which the patients primary language is not English.

List of Attachments:

1. See employee comments.

Patient Experience feedback from Employee Report
August 7, 2023

Suggested Committee Discussion Questions:

1. How will you evaluate the language translation service performance?

2. How do you measure the effectiveness of the pilot?

Patient Experience feedback from Employee Report
August 7, 2023

Written Employee Concern

We had a patient who died suddenly. Wife speaks very little English. I tried to use all the Voyce iPads on 2C to get a Japanese translator. She had a lot of questions. Unable "to connect". Julia (Charge) and I tried several times. Julia (Charge) suggested I used Voyce 2C on Vocera. I asked for a Japanese translator. I was on hold for a long time. I said it was an emergency. They kept telling me they were trying to get a Japanese interpreter. Finally, Jean, the tech said there was no Japanese interpreter and he did not know when there would be one.

I was surprised. I apologized to the patient's wife. She was tearful. I tried my best to explain the situation by speaking slowly and drawings. She still had many questions. I asked if she had family that spoke English. She said her daughter in Japan. I got the telephone number, spoke with ECH Operator, and made a long distance call. I was able to reach the daughter and explained what happened and answered all questions. It was very upsetting.

We need a better language line and we need better support.

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: August 7, 2023
Subject: Enterprise Quality, Safety and Experience and STEEEP Dashboards through June 2023

Purpose:

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

1. **Situation:**

The FY 23 Enterprise Quality, Safety and Experience Dashboard is updated monthly and tracks seventeen 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. Based on discussion at the June 2023 Quality Committee meeting, a single memo will describe the performance of measures in both dashboards.

Enterprise Quality Dashboard
HAC Index
Cdiff
SSI
nvHAP
Falls
HAPI
Serious Safety Event Rate
Readmission Index
Mortality Index
Sepsis Mortality Index
PCO1 Elective Induction Rate
PCO2 NTSV Cesarean Section Rate
ED Throughput Time to Discharge
Inpatient HCAHPS
MCH HCAHPS
ED LTR
ECHMN LTR

STEEEP
HAC Index
Cdiff
SSI
nvHAP
Falls
HAPI
Stroke TTITT
Stroke Door to groin
Imaging TAT
Readmission
Mortality
Sepsis mortality
NTSV Cesarean Section Rate
ED Throughput time to Discharge
Ethnicity documentation
Race documentation
Inpatient HCAHPS
MCH HCAHPS
ED LTR
ECHMN LTR

2. **Assessment**:

   a. **Quality Measures**
      i. **Hospital Acquired Condition Index** (lower is better). This metric is a composite of the weighted rates of 5 component measures:

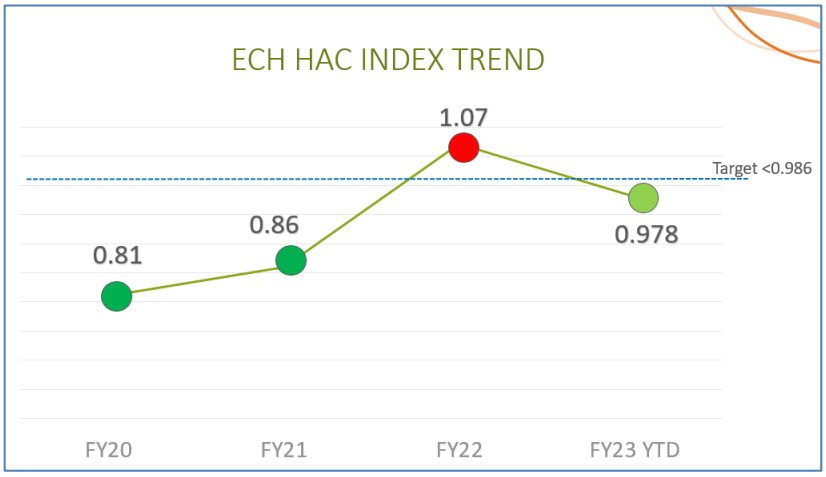
Final FY23 performance, 0.978 exceeded (favorable) the target of 0.986. At the unit and dashboard level the individual measures within the HAC Index are shown as number of events, the numerator only. This was intentional as showing this granular performance enables individual units and departments to set unit specific targets. Each of these measures is tracked for public reporting as a rate. The table below describes the denominator basis for each measure.

FY22 Baseline					
Metric	Num.	Den.	Rate	Weight	Weighted Rate
C. Difficile Infection	37	patient days	xxx	0.10	0.355
Surgical Site Infection	18	# surgeries	xxx	0.25	0.06
nvHospital Acquired Pneumonia	115	patient days	xxx	0.20	0.365
Falls	153	patient days	xxx	0.20	0.265
Hospital Acquired Pressure Injury	8	patient days	xxx	0.25	0.022
HAC Index				Sum »	1.066

The target for FY23 was to reduce the HAC Index (Harm Events) by 7.5%. We exceeded the target. There was an 8.02% reduction in the HAC Index in FY23.

- C Difficile infection rate decreased by 6%
- Pneumonia rate decreased by 13%
- Fall rate decreased by 12%
- Surgical site infection rate increased by 44%
- Pressure injury rate decreased by 55%

HAC Index rending over the past 4 years is displayed in the graph below:



1. **C. Difficile Infection:** Process improvement milestones which led to the successful reduction of C. Diff infection rate by 6% are;
   - October 2022—updated the nursing standard procedure of how to screen for C. Diff infection.

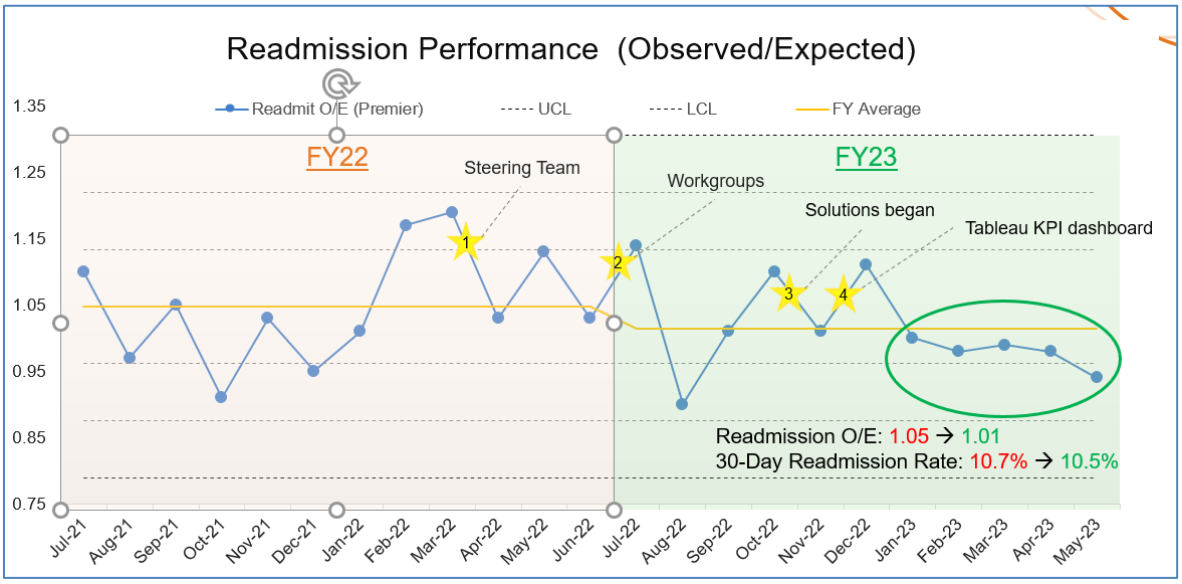
- Deployment of visually compelling and actionable analytics dashboards pushed to the unit managers
- Hand Hygiene campaign with enterprise wide “video singing competition”
- Infection prevention nurse:unit manager dyad patient rounding and on the spot education
- Nurse Educator Hac-A-Thon education and training. Given the # of new staff and per diem staff, this was tremendously impactful given the gaps in real time training forced due to COVID precautions in FY2021 and FY2022.
- EVS excellence, glo gel testing on the nursing units to show staff the omnipresence of bioburden on nursing units if hand hygiene compliance is low.

The impact realized from the cumulative effects of all of these interventions came to bear in the fourth quarter of the fiscal year. We achieved a **29% reduction** in C Diff infection rate in the fourth quarter compared to Q1 and Q2 of FY23.

2. **Non-ventilator Hospital Acquired Infection** rate decreased by 16% compared to FY22. We will continue to focus on nvHAP reduction in FY23 as part of HAC 2.0 as we did not see the improvement we desire and expect. Our interventions and their impact have not been fully realized.
3. **Pressure injuries** reduced most significantly. There were 55% fewer hospital acquired pressure injuries in FY23 compared to FY22. Key interventions were resurrection of the Wound Warrior multiple disciplinary team which was temporarily paused during peak COVID. Additionally our respiratory therapist proactively began assessing and addressing possible skin injuries resulting from respiratory therapy devices such as oxygen masks, nasal cannulas, the elastic band which goes behind the ears to hold breathing devices in place.
4. **Patient fall rate:** Improved by 12% compared to FY22. The successful roll out of the predictive EPIC intelligence tool helped our teams more accurately, and timely, assess a patient’s fall risk resulting in earlier utilization of fall reduction interventions.
5. **Surgical Site Infection:** There was an unanticipated increase in total knee replacement joint infections this year. This alone contributed to the increase in overall infection rate in FY2023. We have engaged an improvement team with the surgeons, our peri-op team, infection prevention and process improvement teams to identify and correct gaps in our processes. I invited my quality executive coach who has expertise in OR infection prevention processes to come to campus (x2) and spend time in our OR suites observing our processes. Our joint surgeons embraced this opportunity and welcomed the consultant into their surgical cases. Key learnings and opportunities for standardization and improvement have been identified.

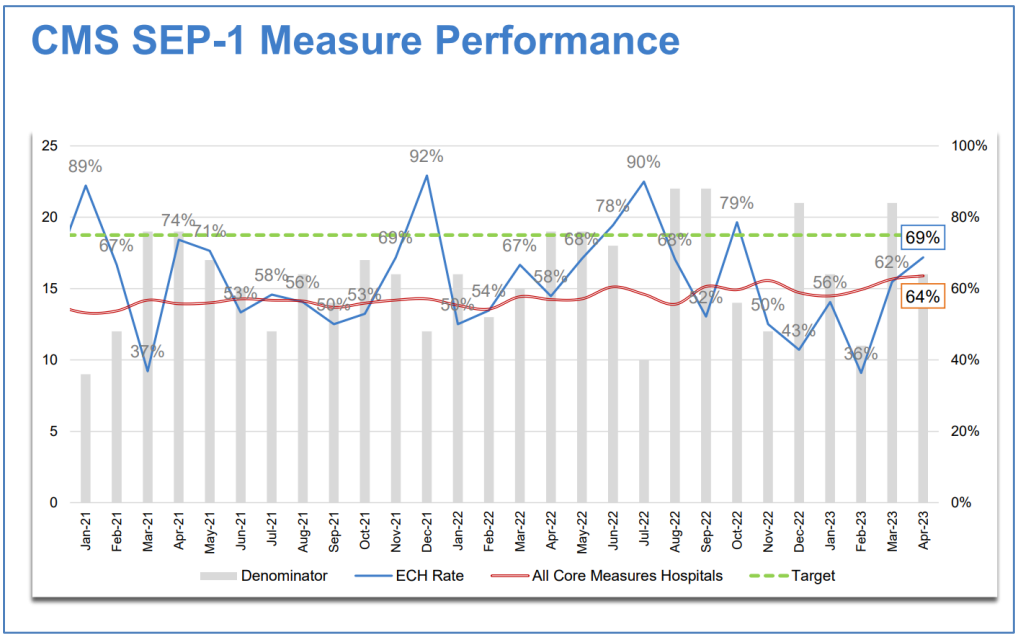
ii. **Readmission Index.** Efforts to reduce readmissions in the face of a disrupted post-acute landscape have been very successful. May readmission index of 0.98 is the fifth consecutive month of outstanding performance with an index < 1.0. The four areas of focus for the past 18 months have been on these 4 patient groups;

1. Patient readmitted for a hospital stay < 48 hours
2. Vulnerable patients who are readmitted > 4 times in 12 months
3. Patients with substance abuse
4. Sepsis patients



iii. **Mortality index.** Performance year to date and in June 2023 was unfavorable to goal. The increase in mortality index is due to the increase in Sepsis Mortality.

iv. **Sepsis Mortality Index.** The improvement (reduction) in the Mortality Index in May 2023 of 0.82 was not sustained and the June index was 1.38. Our sepsis team is in the process of focused review of each case in June to identify opportunities for improvement. In prior Quality Committee meetings I have mentioned the impact the loss of Dr. Cook, the ED Medical Director, has had on Sepsis Performance in the ED. We have established a collaborative partnership with our new ED Medical Director in Mountain View. Just this week we had a level-setting meeting to ensure management of Sepsis Patients in the ED remains the responsibility of the ED team until the patient is actually on the floor. This had changed after Dr. Cook's departure where Sepsis patients 'holding' in the ED were in limbo without clear accountability on which team (ED vs hospitalist) was responsible for managing these fragile patients. The improved communication and partnership with the ED leadership is reflected in the improvement in Core Measure performance through April. This is now at an all-time high since October 2022. Complying with the treatment bundle tracks closely to mortality.



v. **Elective Delivery and Cesarean Birth**: The obstetrical measures are core measures and due to the data validation process and chart abstraction needed, the results lag by 3 months. We have no new data to report since the last update in May 2023.

vi. **Emergency Department Throughput**. This measure assess the time patients evaluated, treated and then discharged home spend in the department. There has been progressive improvement (shortening of time) in this measure on both campuses for the past 4 months. We are at goal in June 2023. Areas of focus are on making the triage process more efficient. Utilizing three new 'treat to street' chairs for less acute patients. The stubborn factor, which impedes further progress, is the nighttime delays in radiology reading times.

vii. **Stroke Measures (STEEEP Dashboard)**. You may recall that throughout FY22 the performance on both measures, door to needle and door to groin, were not at target every quarter. What a difference having an impactful medical director leading the team makes…. Patients presenting with stroke deemed appropriate candidates for IV thrombolytic therapy received the IV medication within 30 minutes 60% of the time (15 of 25). The outliers were within minutes of the goal, (32 minutes, 33 minutes). We also had sustained success with timely treatment of patients who were brought to the cath lab to have a thrombectomy procedure by interventional neurologists. Additionally, El Camino had a successful Joint Commission Stroke survey, receiving praise and accolades from the surveyor as one of the best stroke care centers she has seen, for both of our campuses.

viii. **Imaging turn-around time**: this remains a patient safety concern and is being addressed by changing vendors for the radiologists we contract with to perform readings overnight. Our current night read partner is experiencing staffing shortages, inefficiencies which result in prolonged (>3 hours) read times over night. This is a direct driver of our longer throughput times in the Emergency Departments. Dr. Adams is leading this transition.

b. Patient Experience Measures:

i. **Inpatient HCAHPS Likelihood to Recommend:** Inpatient units overall did meet goal for June, but not for fiscal year to date. MV campus met goals for the past two months and are in the top decile (90th percentile). Unfortunately, our Los Gatos campus has had a myriad of issues with room temperature and comfort of surroundings and we will continue to focus attention on Los Gatos. We continue to emphasize being proactive (nurse leader rounding) and ensuring that bedside shift report is happening.

ii. **Maternal Child Health HCAHPS Likelihood to Recommend:** Mountain View MCH did not meet target for the month of June or for the fiscal year to date. The soft opening for of our new Mother Baby units is in progress and all have embraced these improvements. In addition, staff worked together, a key driver, also increased. The team continues to focus on proactive rounding and service recovery.

iii. **ED Likelihood to Recommend**: The overall ED target was not achieved for June or fiscal year. Both campuses are struggling with staff shortages (LOA, sick calls) and we continue to work on throughput. We are focusing on length of stay on the inpatient units to improve the efficiency of the admission to the floor process our patient's experience. We have a process improvement team working on optimizing the utilization of our discharge lounge. This should also free up more space on inpatient units to alleviate the backlogs of patient's boarding in the ED awaiting an inpatient bed.

iv. **ECHMN Likelihood to Recommend Care Provider**: ECHMN exceeded target for June, which makes five months in a row! The FY23 goal was not met, but substantial improvements were see in likelihood to recommend care provider and likelihood to recommend clinic. Responses from patients to questions about access and wait times improved throughout the year.

Attachments:

1. Enterprise Quality, Safety and Experience Dashboard through June 23
2. STEEEP Dashboard through Q4 of FY23

Month to Quality Committee of the Board: August, 2023

El Camino Health

FY23 Quarterly Board Quality Dashboard (STEEEP)

Quality Domain	Metric	Past Performance				Baseline	Target	Current Performance				
		FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY 22	FY 23	FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	FYTD
Safe Care	HAC Index	1.05	1.3	1.6	0.86	1.066	**0.986**	0.803	1.295	0.964	1.440	**0.978**
	HAC Component: Clostridium Difficile Infection (C.diff)	8	8	7	14	9.25	**8.56**	7	13	9	6	**8.75**
	HAC Component: Surgical Site Infections (SSI)	5	4	7	2	4.5	**4.16**	6	11	4	6	**6.75**
	HAC Component: nvHAP	36	29	26	24	28.75	**26.59**	26	31	20	39	**29.00**
	HAC Component: IP Units area Patient Falls Reported to NDNQI	26	48	47	32	38.25	**35.38**	25	50	35	33	**35.75**
	HAC Component: HAPI Stage 3, Stage 4 and Unstageable	0	3	3	2	2.00	**1.85**	2	2	0	0	**1.00**
Timely	Stroke: TTITT (time to intravenous thrombolytic therapy) <= 30 min	25% (1/4)	10% (1/10)	75.0% (6/8)	0% (0/6)	28.6% (8/28)	**50%**	50% (4/8)	71.4% (5/7)	75.0% (3/4)	50.0% (3/6)	**60.0% (15/25)**
	Stroke: Door-to-Groin <= 90 minutes	50% (1/2)	28.6% (2/7)	50% (1/2)	25% (1/4)	33.3% (5/15)	**50%**	100% (2/2)	75.0% (3/4)	50.0% (3/6)	N/A	**66.7% (8/12)**
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)	80.35%	79.68%	82.26%	74.14%	79.01%	**84%**	78.43%	78.34%	78.28%	77.01%	**78.02%**
Effective	Risk Adjusted Readmissions Index	1.05	0.96	1.12	1.06	1.05	**1.00**	1.02	1.10	0.99	0.97	**1.03**
	Risk Adjusted Mortality Index	0.99	0.92	0.99	0.85	0.94	**0.85**	1.03	1.08	1.10	1.08	**1.08**
	Risk Adjusted Sepsis Mortality Index	1.07	1.01	1.10	0.91	1.02	**0.98**	1.02	1.27	1.17	1.07	**1.13**
	PC-02 NTSV C-Section	25.8%	25.0%	24.1%	28.3%	25.80%	**23.5%**	28.8%	24.7%	24.0%	N/A	**25.9%**
Efficient	Median Time from ED Arrival to ED Departure (Enterprise)	160 min	156 min	162 min	169 min	162 min	**162 min**	176 min	168 min	169 min	165 min	**170 min**
Equitable	% Patients - Ethnicity documented	98.1%	97.9%	97.8%	97.8%	97.9%	----	97.6%	97.0%	96.6%	96.6%	**97.0%**
	% Patients - Race documented	98.6%	98.5%	98.0%	98.1%	98.3%	----	97.8%	97.3%	97.3%	97.5%	**97.5%**
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	82.0	80.2	81.5	79.4	80.8	**81**	79.9	78.8	76.6	78.4	**78.5**
	ED - Likelihood to Recommend (PG)	73.1	75.8	77.4	71.5	74.5	**75**	70.3	72.3	73.8	70.4	**71.7**
	MCH - HCAHPS Likelihood to Recommend	79.4	81.0	82.1	82.8	81.3	**81.5**	72.3	72.1	**83.7**	74.0	**75.0**
	ECHMN (El Camino Health Medical Network)	---	---	83.6	82.8	83.2	**83.4**	81.1	81.6	83.6	83.8	**82.7**

Updated: 7/19/23

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**

Cell: N7
Comment: Mary_Mc:
This displays the FYTD quarterly average.

Cell: B16
Comment: Readmission Index FY23Q2: displaying 2 months only; too early to run December '22 Readmission Index. MMc

Cell: B19
Comment: PC-02 Calendar:
FY22Q4 will be submitted to CMS 11/1; then reported on next STEEEP Feb, '23. FY23Q1 will be available for reporting after 2/1/23 upon submission to CMS. MMc

Cell: B20
Comment: Arith Obs LOS/Geo Exp LOS: Sep, '22 previously reported data was based upon all inpatients instead on only Medicare Inpatients. Corrected past data; notified Sr. Leadership. MMc

Cell: B23
Comment: % Ethnicity: New for FY23; no target. Definition: Numerator: % that are populated with a valid value - excluding: Blanks, Refused to Answer or Unknown. Population: Inpatients (Patient Type = Inpatient) + ED + Outpatients Patient Type = Observation or Surgical Day Care). MMc

Cell: B24
Comment: % Race: New for FY23; no target. Definition: Numerator: % that are populated with a valid value - excluding: Blanks, Refused to Answer or Unknown. Population: Inpatients (Patient Type = Inpatient) + ED + Outpatients Patient Type = Observation or Surgical Day Care). MMc

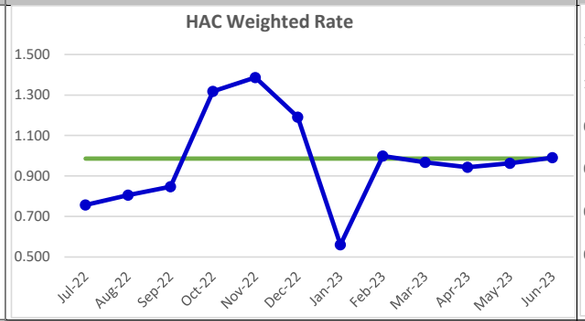
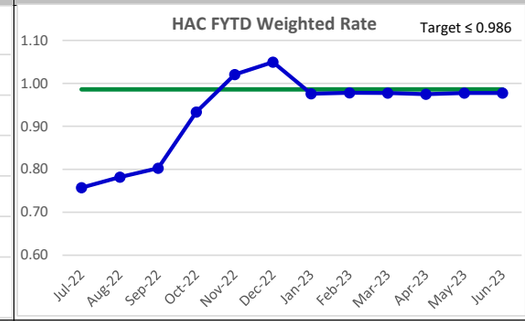
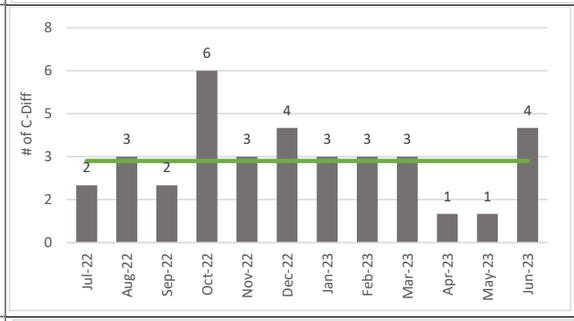
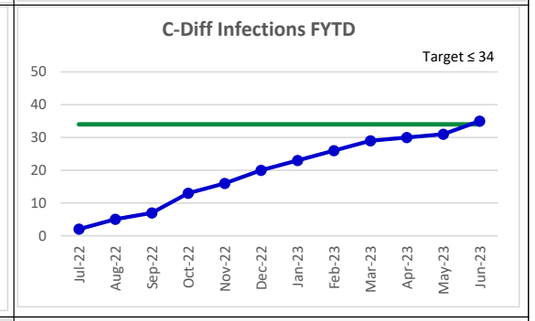
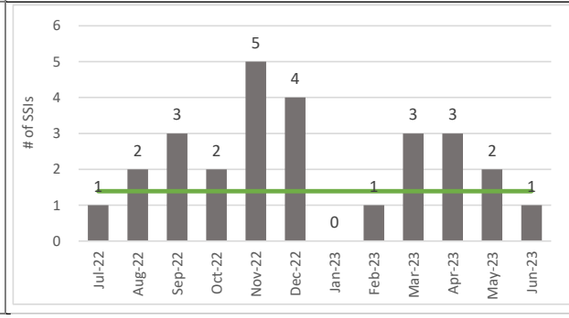
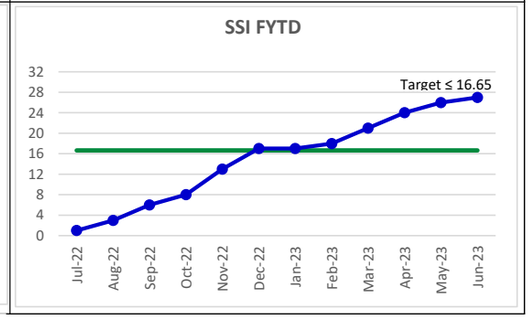
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

June 2023 (unless otherwise specified)

Month to Board Quality Committee:

August, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **HAC Index** *Latest data month: June, 23* **Preliminary*	0.991	0.978	1.066	0.986 (7.5% ↓)		
2	HAC component **Clostridium Difficile Infections (C-Diff)** *Latest data month: June, 23* **Preliminary*	4	2.92 / month	3.08 / month	2.85 / month		
3	HAC component **Surgical Site Infections (SSI)** *Latest data month: June, 23* **Preliminary*	1	2.25 / month	1.50 / month	1.39 / month		

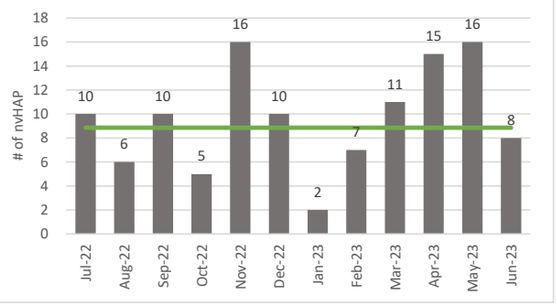
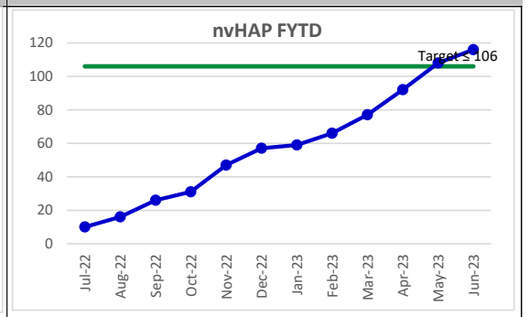
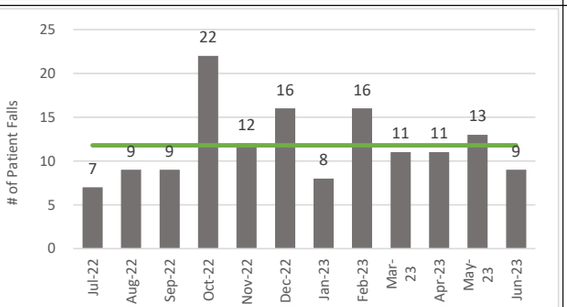
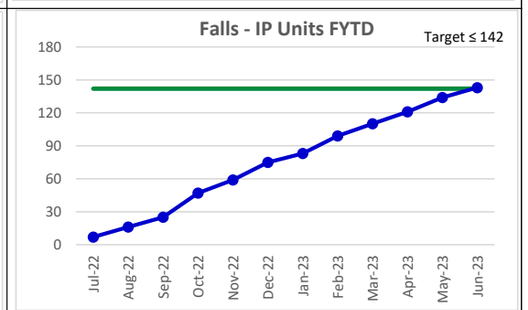
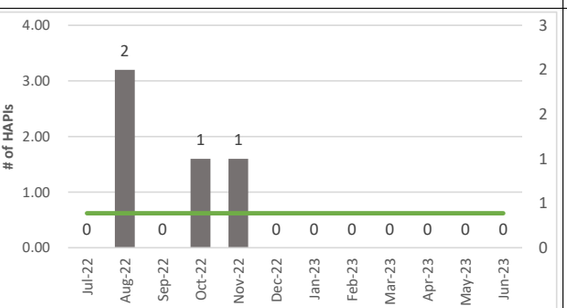
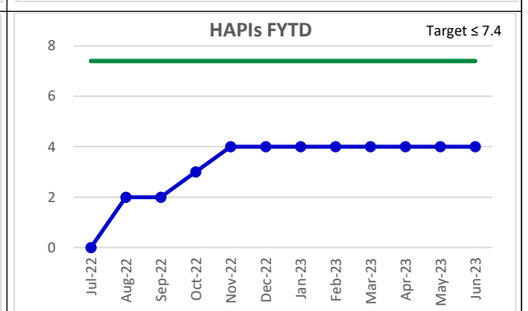
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

June 2023 (unless otherwise specified)

Month to Board Quality Committee:

August, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
4	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: June, 23* **Preliminary*	8	9.67 / month	9.58 / month	8.86 / month		
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: June, 23* **Preliminary*	9	11.92 / month	12.75 / month	11.79 / month		
6	**HAC component** **HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury** *Latest data month: June, 23* **Preliminary*	0	0.33 / month	0.67 / month	0.62 / month		

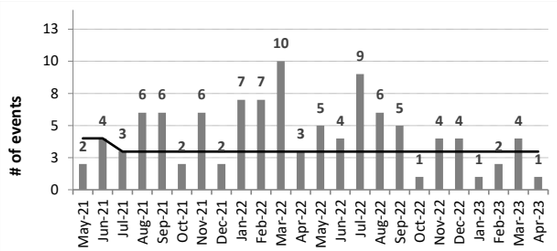
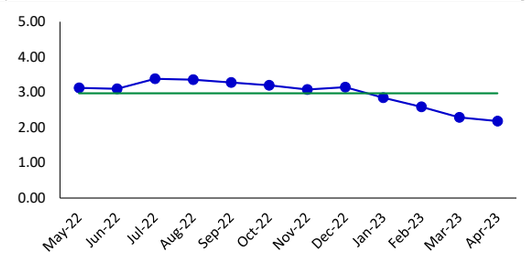
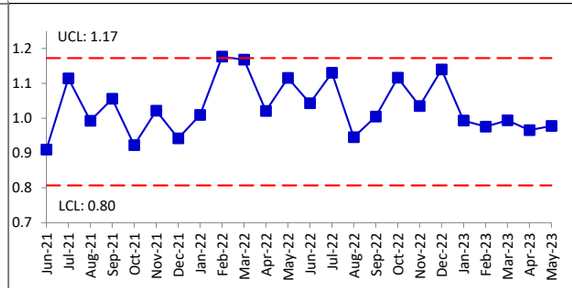
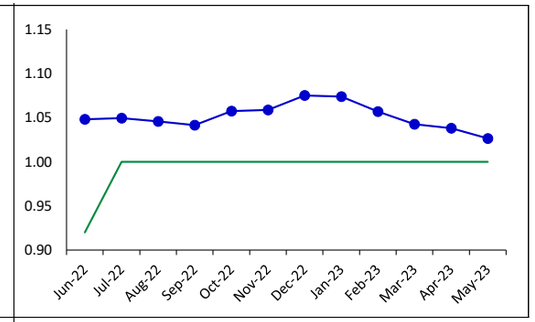
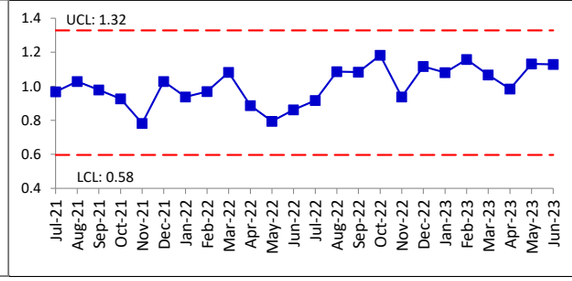
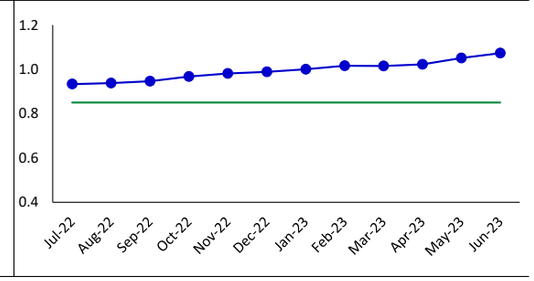
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

June 2023 (unless otherwise specified)

Month to Board Quality Committee:

August, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
7	**Serious Safety Event Rate (SSER)** **Latest data month: Apr, 23*	1	2.18 (46/210829)	3.10 (Jul, 21 - Jun, 22)	n/a		
8	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** ** Latest data month: May, 23*	0.98 (8.77%/8.97%)	1.03 (9.12%/8.89%)	1.05	1.00		
9	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: June, 23*	1.13 (2.45%/2.17%)	1.08 (2.20%/2.05%)	0.94	0.85		

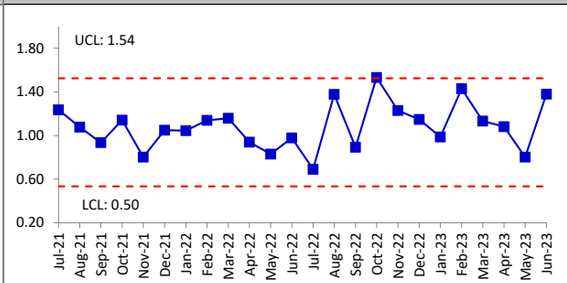
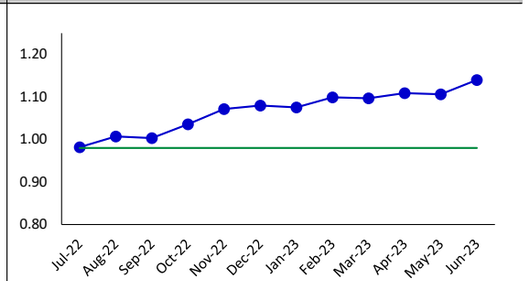
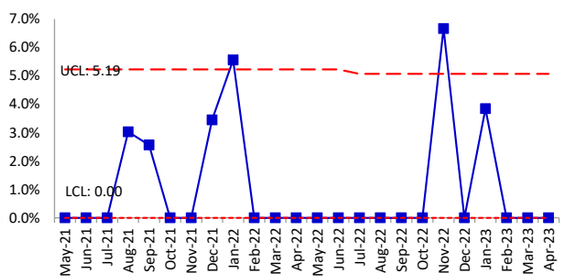
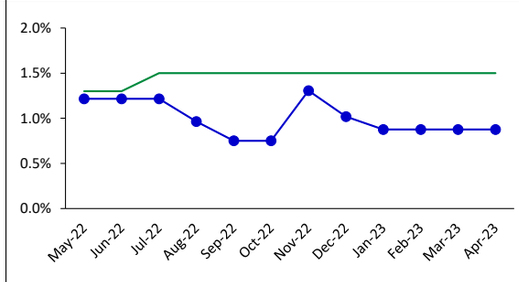
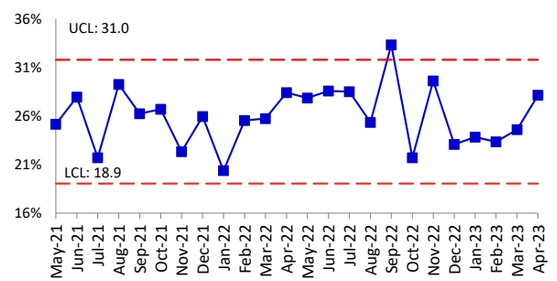
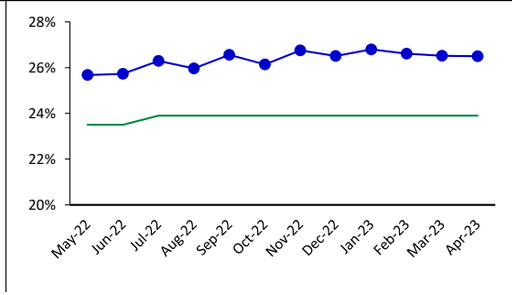
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

June 2023 (unless otherwise specified)

Month to Board Quality Committee:

August, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
10	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: June, 23*	1.38 (17.60%/12.76%)	1.13 (13.82%/12.18%)	1.02	0.98		
11	**PC-01: Elective Delivery Prior to 39 weeks gestation** (reported quarterly) **Latest data quarter: Apr, 23*	MV: 0.0% (0/23) LG: 0.0% (0/6) ENT: 0.0% (0/29)	MV: 0.9% (2/227) LG: 0.0% (0/64) ENT: 0.7% (2/291)	MV: 0.4% (1/271) LG: 3.5% (3/83) ENT: 1.1% (4/356)	1.5% (FY23 Target)		
12	**PC-02: Cesarean Birth** (reported quarterly) **Latest data quarter: Apr, 23*	MV: 30.2% (51/172) LG: 14.8% (4/27) ENT: 28.1% (56/199)	MV: 27.4% (437/1596) LG: 18.9% (51/270) ENT: 26.2% (488/1866)	MV: 27.1% (503/1,857) LG: 19.9% (83/147) ENT: 25.8% (586/2,274)	23.9% (FY23 Target)		

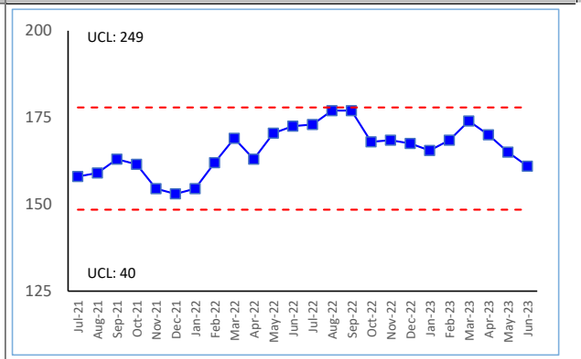
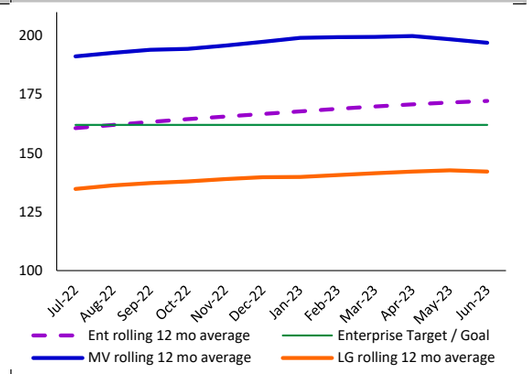
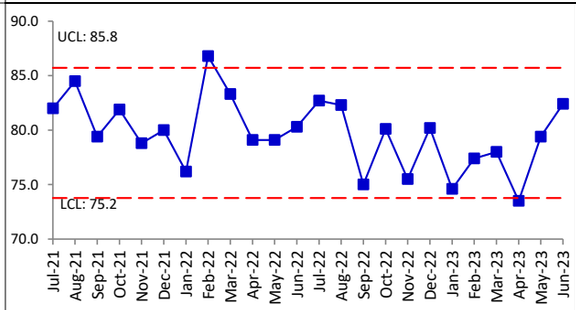
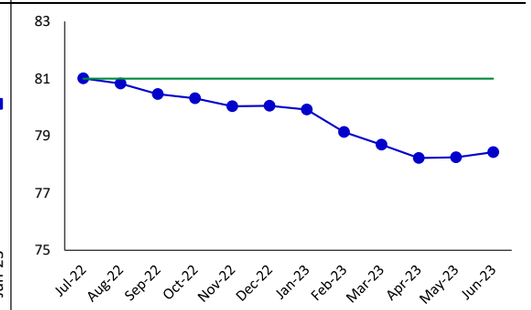
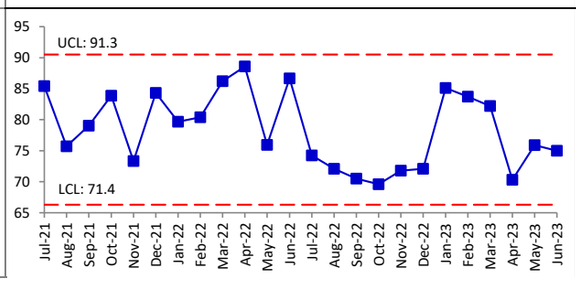
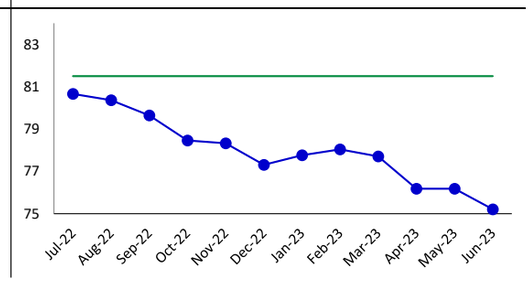
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

June 2023 (unless otherwise specified)

Month to Board Quality Committee:

August, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
13	**Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: June, '23*	MV: 186 mins LG: 136 mins ENT: 161 mins	MV: 197 mins LG: 142 mins ENT: 170 mins	MV: 190 mins LG: 133 mins Ent: 162 mins	MV: 190 mins LG: 133 mins Ent: 162 mins		
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: June, 23*	82.4	78.5	80.8	81.0		
15	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: June, 23*	75.0	75.0	81.3	81.5		

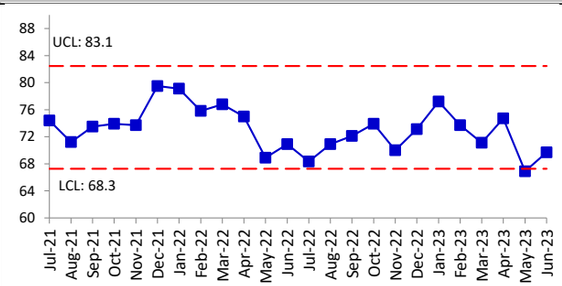
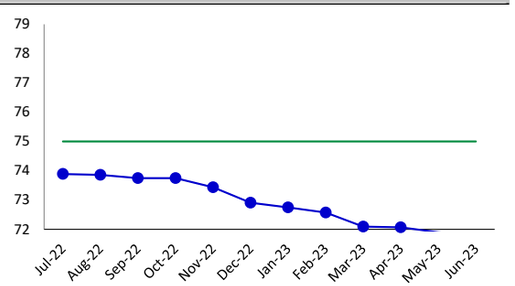
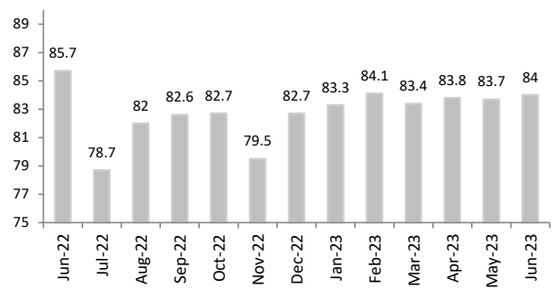
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

June 2023 (unless otherwise specified)

Month to Board Quality Committee:

August, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
16	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: June, 23*	69.7	71.7	68.4	75.0		
17	*** Organizational Goal** **ECHMN (El Camino Health Medical Network) : Likelihood to Recommend Care Provider** **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Unadjusted** *Latest data month: June, 23*	84.0	82.7	83.2	83.4		NA

Notes:

1) SSER through Apr, 23
2) Readmissions through May, '23
3) PC-01 & PC-02 results available up to April 2023
4) ECHMN: reflect new vendor (PG) survey results
5) Updated 7/18/23

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
1	*Organizational Goal **HAC Index** *Latest data month: June, 23* **Preliminary*		H. Beeman, MD	New for FY23, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (5) key inpatient safety events. The elements of the composite are weighted as noted: Falls 20%, hospital-acquired Pressure Injuries (HAPIs) 25%, non-ventilator hospital-acquired pneumonia (nvHAP) 20%, Clostridium difficile infections (C-Diff) 10%, and surgical site infections (SSIs) 25%.	See below
2	HAC component **Clostridium Difficile Infections (C-Diff)** *Latest data month: June, 23* **Preliminary*		C. Nalesnik	1) Based on NHSN defined criteria: inclusions: Inpatients, Peri-Op, Behavioral Health; exclusions: Rehab, NICU, outpatients, ED patients 2) All positive C.diff Toxin/antigen lab tests that result on or after the patient's 4th day of hospitalization 3) Latency: C-Diff infections may be identified up to 30 days, thus previously reported results may change.	Numerator: Infection control Dept. Denominator: EPIC Report
3	HAC component **Surgical Site Infections (SSI)** *Latest data month: June, 23* **Preliminary*		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

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
4	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: June, 23* **Preliminary*		C. Delogramatic	1) Internal metric: Inpatient non-ventilator hospital-acquired pneumonia cases. 2) Numerator inclusions: inpatients (18+yrs) w/ a specified pneumonia diagnosis code(s) with POA (present on admission) status of "N" (acquired during the hospital encounter), that is unrelated to mechanical ventilation; monthly, cases are reviewed & confirmed by the nvHAP workgroup. 3) Denominator EPSI patient days excluding 6070 NICU/Nursery Lvl 2, 6310/6315 MBU, 6340 Behavioral Health, 6440 IP Rehab, 6900 Pre-Op SSU, 7400 L&D, 7427 PACU 5) Latency: periodic; corrections may change previously reported results.	EPIC Clarity data warehouse; Numerator identified by nvHAP workgroup; Denominator: EPSi patient days
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: June, 23* **Preliminary*		Nursing	1) NDNQI metric: In or outpatient falls on an inpatient nursing unit. "Falls" in a nursery are 'drops'. 2) Numerator inclusions: Patient falls as determined by a monthly evaluation & validation of iSAFE incident reports. 3) Numerator exclusions: L&D, intentional falls. 4) Denominator: EPSi acute patient days excluding: 6900 Pre-OP/SSU, 7400 L&D, 7427 PACU 5) Formula: (# falls/patient days) * 1,000 6) Latency: rare; corrections may change previously reported results.	Numerator: Incident Reports and Staff Validation/iSafe Denominator: EPSi patient days
6	**HAC component** **HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury** *Latest data month: June, 23* **Preliminary*		A. Aquino	1) Internal metric: Inpatient Stage 3, Stage 4 & Unstageable hospital-acquired pressure injuries 2) Numerator exclusions: Expirations, "skin failure/ Kennedy Pressure Ulcer" & proned Covid-19 patients 3) Denominator: EPSi acute patient days excluding 6070 NICU/Nursery Lvl 2, 6900 Pre-Op SSU,7400 L&D, 7427 PACU 4) Latency: periodic; corrections may change previously reported results.	Numerator: EPIC Report and staff validation Denominator: EPSi patient days

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
7	**Serious Safety Event Rate (SSER)** **Latest data month: Apr, 23*		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
8	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** * Latest data month: May, 23		H. Beeman, MD	1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause). 2) Based upon Premier's Care Sciences Standard Practice risk-adjustment + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient 4) NOTE: Excludes cases discharged from (1) hospital, then readmitted to the other hospital w/in 30D. For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Premier Quality Advisor
9	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: June, 23*		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

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
10	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: June, 23*		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
11	**PC-01: Elective Delivery Prior to 39 weeks gestation** (reported quarterly) *****Latest data quarter: Apr, 23*		H. Beeman, MD	1) Numerator: Patients with elective deliveries 2) Denominator: Delivered newborns with gestation weeks >/= 37 to 39 weeks For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value ,/= zero. 9/16/22 (per H. Freeman): The FY23 target for PC-01 1.5% (top 25th %ile for MDC). MCH needs to retain some ability to do medically indicated, yet not meeting criteria, early deliveries.	IBM CareDiscovery Quality Measures
12	**PC-02: Cesarean Birth** (reported quarterly) *****Latest data quarter: Apr, 23*		H. Beeman, MD	1) Numerator: Patients with cesarean births 2) Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value ,/= zero. 9/16/22 (per H. Freeman): FY23 target for PC-02 NTSV is 23.9%. Given our population (Asian average in CA was 25.2% from 07/2021-06/2022 for same nursery level CA MDC, + have significantly older population than CA), we think this is pretty aggressive.	IBM CareDiscovery Quality Measures

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
13	**Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: June, '23*		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
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: June, 23*		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
15	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: June, 23*		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

El Camino Health

Definitions and Additional Information

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

Notes:

1) SSER through Apr, 23
2) Readmissions through May, '23
3) PC-01 & PC-02 results available up to Apr
4) ECHMN: reflect new vendor (PG) survey
5) Updated 7/18/23

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Shahab Dadjou, President ECHMN and Ute Burness, RN, VP of Quality, ECHMN
Date: August 7, 2023
Subject: ECHMN Quarterly Quality Report

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

Summary:

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

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

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

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

A. Clinical Excellence, Dependable and Convenient Care
B. Patient Experience (Likelihood to Recommend (LTR))
C. Merit Base Incentive Payment System (MIPS)

ECHMN has established true north pillars, one of which is quality and service. Starting June 1, 2023, ECHMN changed its quality reporting methodology. The methodology measures the performance of PCP attributed patients on six (6) clinical indicators. These measures were selected because they are important measures of health and consistent with the priorities of our health plan partners and with Centers for Medicare and Medical (CMS). ECHMN tracks the performance to targets. We have met target for five (5) of six (6) clinical measures. ECHMN has made the most significant improvement in the blood pressure control metric. In the 4th quarter, we implemented the “Red Heart” campaign, which was putting a red heart on the door of every patient that needed to have their second blood pressure taken before they left their visit. The campaign also included sending a “my chart” messages asking the patients to self-report their blood pressure from home. These targeted initiatives helped us achieve our result of 70.5% (included in the slide deck). Documentation of medications at the time of visit was not met; a corrective action plan is included in the attached slide deck.

For the dependable and convenient domain, third next available (3NA) remains unfavorable for primary care and specialty care. The clinical response to patient

messages also did not meet target. The attached slide deck, describes the corrective action plan that is in place.

Likelihood to Recommend (LTR) for fiscal year 2023 was a year of improvement with five consecutive months of meeting or exceeding the goal. A 5.3-point change improvement by the end of the fiscal year. The attached slide, describes the action plan that in place.

MIPS is based on calendar year performance. The 2022 data was submitted in March. The preliminary score is 89.35. A score of 89 is required to achieve exceptional status. The final score will be released from CMS this fall.

List of Attachments:

Power Point background material to pre-read to facilitate the discussion and use as a reference for discussion.

Suggested Committee Discussion Questions:

What additional information would be helpful for the committee to have to satisfy any concerns about quality and service in ECHMN?

El Camino Health

ECH Quality Committee Meeting
ECHMN Quality Update

August 7, 2023

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

Agenda

- **Clinical Domain**
  - FY23 Results
  - FY24 Quality Measures (*approved by ECHMN Board)*
- **Dependable and Convenient Domain**
  - FY23 Results
- **Patient Experience Domain**
  - FY23 Results
  - FY24 Plan

Clinical Domain

Clinical Domain 2023 Results

Achieved 5 of 6 clinical metrics for fiscal year 2023

Measure	Baseline FY22	FY23 Target	FY23	2 Year Trend
Controlling Blood Pressure	60%	65%	70.5%	⬆ 10.5%
Diabetes Management - HbA1C <9% *(Lower number is better)*	24%	<20%	18%	⬆ 6%
Breast Cancer Screening	68%	69%	77%	⬆ 9%
Colon Cancer Screening	57%	61%	68%	⬆ 11%
Annual Flu Vaccination	70%	71%	75%	⬆ 4%
Medication Reconciliation	98%	98.40%	96%	⬇ 2%

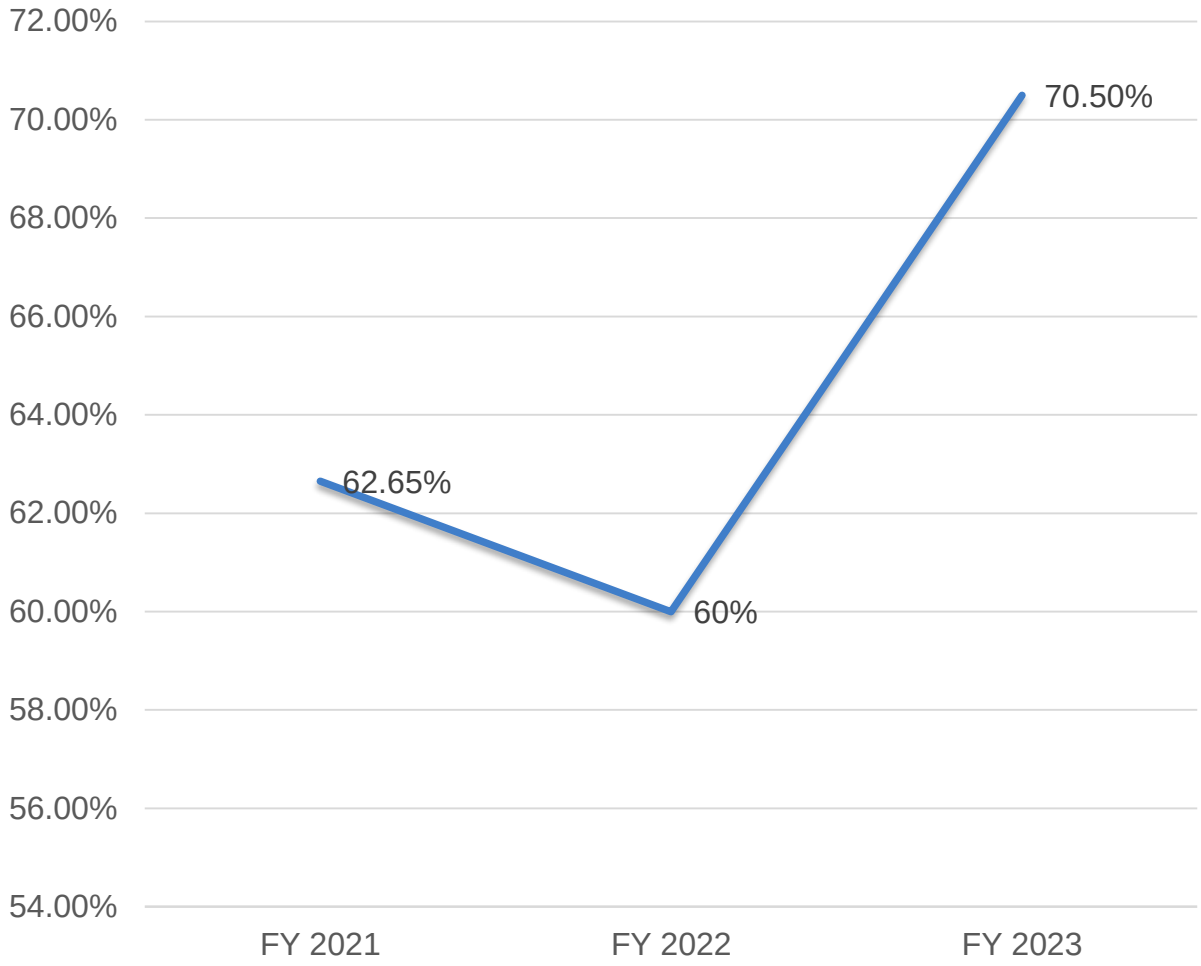
El Camino Health

Clinical Domain Performance – Corrective Action Plan

Measure	Results	Action Plan
Controlling Blood Pressure	• Target met	• No action necessary
Diabetes: Management - HbA1C <9%	• Target met	• No action necessary
Breast Cancer Screening	• Target met	• No action necessary
Colon Cancer Screening	• Target met	• No action necessary
Annual Flu Vaccination	• Target met	• No action necessary
Medication Reconciliation	• Target not met	• Identify Physicians and APPs not meeting target • Dr. Khabra to provide Physician to Physician education to those not meeting target • Implement “hard stop” in EPIC

Controlling Blood Pressure Trending FY 2021 - FY 2023

- FY21 had a higher number of telehealth visits due to Covid-19. Many of the patients did not have blood pressures taken, as they did not have a blood pressure cuff at home.
- FY22 had a decrease due to inconsistency in taking a second blood pressure at time of visit.
- FY23 had improvements after implementation of second blood pressure check and self reporting.

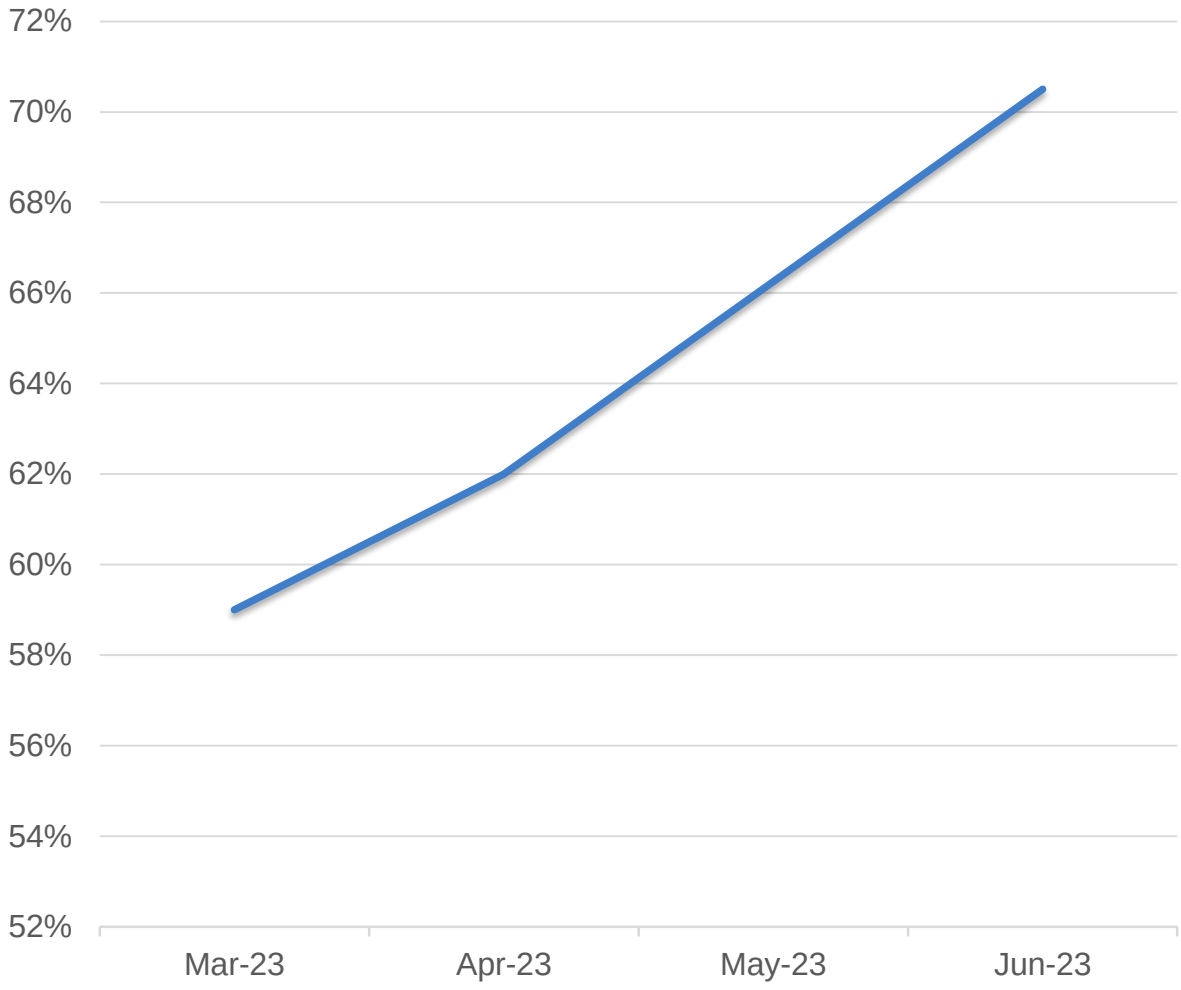


El Camino Health

Controlling Blood Pressure Trending FY 2023: March - June

Controlling Blood Pressure measure increased by 11.5% from March to June. This is a direct result of the following best practices:

- Rechecking the patient's blood pressure if it is elevated at the time of the visit.
- Providing educational materials on how to properly take a blood pressure.
- "Mychart" Blood Pressure Campaign; Patients whose blood pressure was out of control were sent a "My chart" message to self report their blood pressure.
- Implementation of the "Red Hearts" Campaign; a red heart sign was placed on the door of patients that needed a second blood pressure check before the end of their appointment.



El Camino Health

Controlling Blood Pressure Improvement Activities

- On May 22, 2023 a Mychart message was sent to 1,937 patients with blood pressure (BP) not within normal limits to self-report their current BPs at home. On June 14, 2023 a second message was sent to those patients who did not respond to the first Mychart message. The results yielded 437 responses (22.6%).
- Self-reporting increased performance by 5%.
- The “Red Heart” campaign was initiated in early June 2023 in the clinics to improve communication around patients needing a second blood pressure check.
- The “Red Heart” campaign improved the staff doing a second blood pressure at the time of the visit.
- Since implementing these 2 activities, we have seen an 8.5% increase in our blood pressure management. We were at 62% on April 30 and 70.5% at the end of June.

Staff at the Willow Glen Location with the “Red Heart”

FY24 Clinical Domain Measures

Clinical Domain Measures FY24

- **In consultation with the ECH CQO, industry leaders and ECHMN Quality Committee, management proposed redesign of future Quality metrics and measuring period. As a result, the following changes were reviewed and approved by the ECHMN Board.**

  1. Change measurement period from fiscal year to calendar year.
  2. During transition, measure calendar year 2023, which includes one-half of 2023.
  3. Increase Quality measures to eight (8) core measures and three (3) radar measures.
     - *Core measures are priority measures with a higher level of focus.*
     - *Radar measures are important for future changes with CMS.*

- **The new approach better aligns with the industry, CMS, payers and population health.**

Core Quality Measures and Targets – Calendar Year 2023

Core Measures	Measure Description	FY23 Results*	CY23 Targets
Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the past 27 months.	77%	Pending
Diabetes - Hemoglobin A1c Poor Control >9%	Percentage of patients 18-75 years of age with diabetes who had a Hemoglobin A1c >9%.	18%	Pending
Colorectal Cancer Screening	Percentage of adults 45*-75 years of age who had appropriate screening for colorectal cancer.	68%	Pending
Tobacco - Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use and if they use tobacco appropriate cessation intervention done.	NA	Pending
Fall Risk Screening	Percentage of patients aged 65 years and older who are screened for future fall risk.	98%	Pending
Controlling Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	70.5%	Pending
Statin Therapy	Percentage of patients, who were prescribed or were on statin therapy during the measurement period: Adults aged 21 years with an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD).	NA	Pending
Reconciliation of Current Medications	Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter.	96%	Pending

Radar Quality Measures and Targets – Calendar Year 2023

Radar Measures	Measure Description	FY23 Results*	CY23 Targets
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the eligible encounter.	NA	46%
BMI Screening and Intervention	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or within the previous twelve months AND who had a follow-up plan documented if most recent BMI was outside of normal parameters.	83%	No Target
Diabetes - Kidney Health	Percentage of patients aged 18-75 years with a diagnosis of diabetes who received a kidney health evaluation defined by an Estimated Glomerular Filtration Rate (eGFR) **AND** Urine Albumin-Creatinine Ratio (uACR) within the measurement period.	NA	No Target

Dependable and Convenient Care Results

Dependable, Convenient and Experience Domain – FY23 Results

Domain	Measure	Baseline FY22	FY23 Target	FY 23
Dependable and Convenient	Access 3na for Primary Care (Access Third Next Available – Lower is better)	18.1 days	13.5 days	18.7 days
	Access 3na for Specialty Care (Access Third Next Available – Lower is better)	20.4 days	15.3 days	23.9 days
	Patient Enrollment in Mychart	63%	63%	72.9%
	Clinician Response to Patient Messages < 48 hours	1.48 days	1.2 days	1.6 days
Experience	Primary Care LTR (Likelihood to Recommend)	83.2%	84.8%	82.6%
	Specialty Care LTR (Likelihood to Recommend)	86.8%	87.9%	84.4%
	Urgent Care LTR (Likelihood to Recommend)	78%	80.7%	77.2%

El Camino Health

Dependable, Convenient Domain – Corrective Action Plan

Measure	Results	Contributing Factors	Action Plan
Primary Care 3rd Next Available (3NA)	Target not met	• 1.6 Full time employee (FTE) PCP's departed during the fiscal year. • Changes were made to the number of long visits a PCP has each day (this pushes out new patient and complex office visit access). • Increased utilization of Flexible Time Off (FTO). • Several PCPs not meeting their daily visit targets. • 3NA does not adjust for FTE, not all PCP's work full time. • 4 PCP's have closed practices.	• PCP Recruitment underway for 9 candidates. – 1 signed contract. – 3 pending contract signature. – 5 pending recruitment process. • 2 PCPs are piloting same day appointment access, if this is successful will roll out to other PCPs. • 1 PCP piloting e-visits (office visit alternative with online messaging only), if this is successful, will roll out to other PCPs. • Medical Group leadership to manage time off requests. • Review and consider changes to the FTO policy. • Develop a provider-wide calendar view of time off requests.
Specialty Care 3rd Next Available (3NA)	Target not met	• 3.0 FTE Specialist departed during the fiscal year. • Over-demanded, outlier specialties (ECHMN has >68,000 lives): – GI: 1.2 FTE, Rheum: 0.75 FTE. • Cardiology has decreased access at WG by 50%; patients diverted to ACS at Mountain View. • Single specialists have poorer access when demand increases. • Increased utilization of FTO. • 3NA does not account or is not adjusted for traveling physicians (Spine, Endo, Neurology, Rheum).	• Recruitment for GI and Rheumatology physicians underway; – Physician Assistant (PA-C) in GI starting in August 2023. – Actively recruiting Rheumatology & GI physicians. • Medical Group leadership to oversee time off requests to manage access. • Review and consider changes to the FTO policy. • Develop a provider-wide calendar view of time off requests.

Dependable, Convenient Domain- Corrective Action Plan- con't.

Measure	Results	Contributing Factors	Action Plan
Patient Enrollment in Mychart	Target Met	• n/a	• No action necessary
Clinical Message Response Time	Target not met	• Clinical Messages have grown: – Advice requests: 17% – Rx renewal requests: 36% – User-initiated messages: 33% – Total messages: 28,149 in Q2 2022 to 35,833 in Q2 2023 (21% increase) • Measure includes all calendar days; not business days only and there are no staff assigned to work these messages on weekends. • Medical Assistants (Mas) are not responding to messages in a timely manner in some practices. • Physicians who were self-covering in-baskets on flexible time off (FTO) were not checking messages in a timely manner. • Rx renewals have 14-day auto-batching closure which counts against average response time (increasing Rx renewals to 4.5 days). • Urgent care messages are averaging 14 days due to the Rx auto-batching function.	• Work with Epic to remove 14-day auto-batching function for prescriptions. • Train all MAs on correct In basket message handling and pool attachment. • Train Physicians on pool detachment. • Work with individual Physicians to re-educate their patients on correct/appropriate use of MyChart messaging and the timing of expected response. • Fill open RN positions to assist with In basket. – 2 RNs are currently in place and have assisted 5 Physicians. • Physicians now have a buddy system and they are being trained to cover each other.

Patient Experience FY23 Review

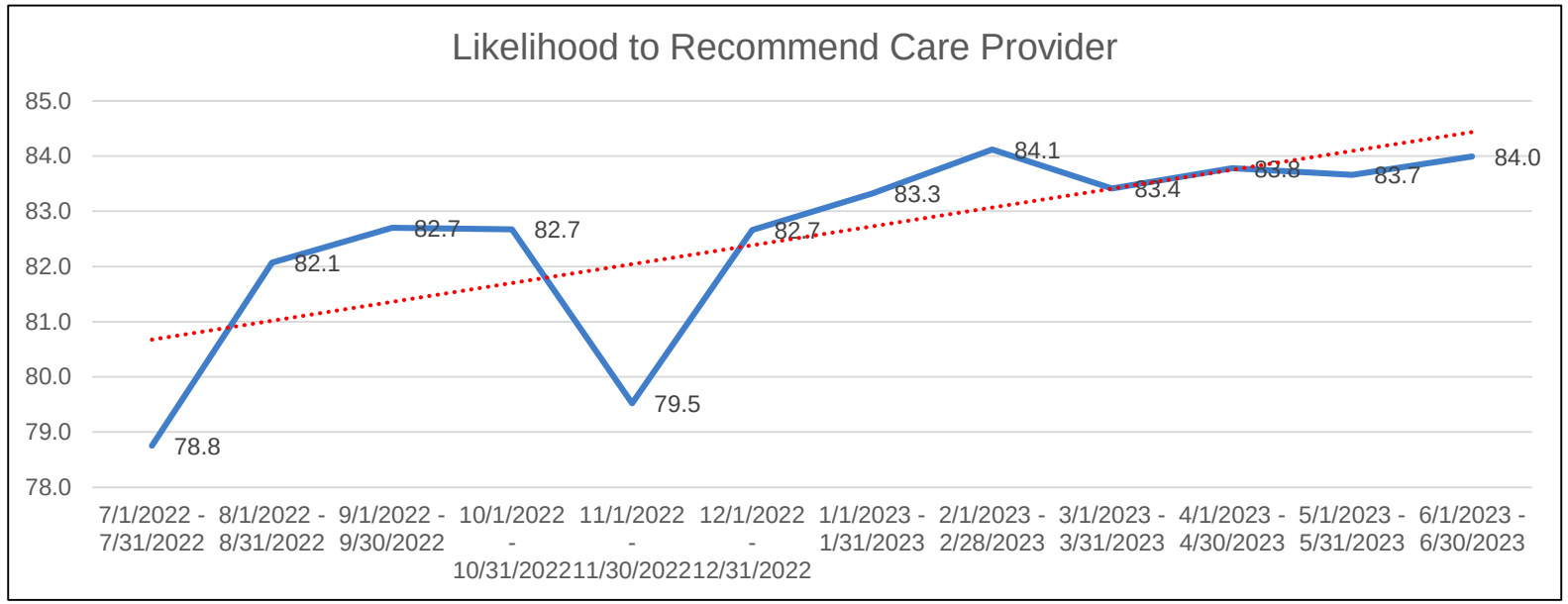
Christine L. Cunningham, CPXP, MBA

FY23 Executive Summary

- FY23 was a **year of improvement** for ECHMN patient experience:
  - New leadership
  - Stability of staffing
  - Laser focus on patient experience best practices
  - Operational improvementss
- +5.3 point change improvement by end of FY23
- Improvement in scores across **ALL frictionless questions**

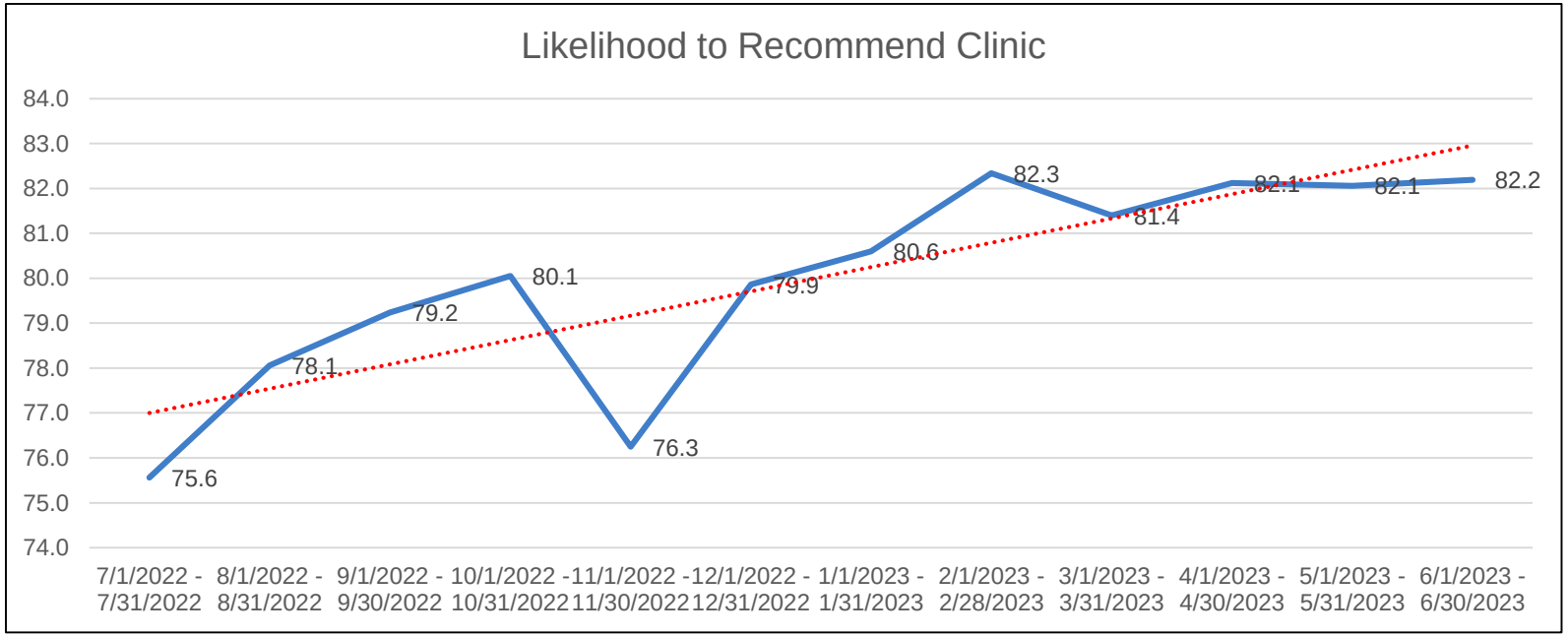
ENTERPRISE		FY23 Target Goals	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	FYTD
*ECHMN - All	LTR CP Top Box Score	83.4	78.8	82.1	82.7	82.7	79.5	82.7	83.3	84.1	83.4	83.8	83.7	84.0	82.7
	National Facilities %tile Rank		13	25	28	27	16	27	30	34	30	31	30	31	25
	Sample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

FY23 Outcomes



+5.2 points

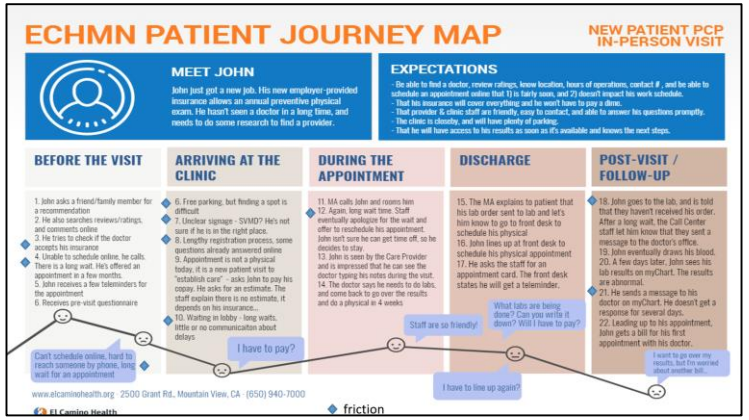
+6.6 points



El Camino Health

ECHMN Patient Friction Points

- Points of friction that make the experience ‘harder’
- Track friction points across entire enterprise
- Work with managers/clinics to identify solutions



ECHMN Frictionless Experience Dashboard

		Source	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	↑/↓ Top Box	FYTD
LTR (All)																
Access	Ability to get desired appointment	Press Ganey	60.5	64.9	64.6	66.3	64.3	69.3	68.9	67.5	66.6	69.1	67.6	69.4	↑	66.8
Access	Ease of scheduling appointment	Press Ganey	61.8	67.0	68.2	69.4	67.2	71.3	71.9	71.2	71.2	71.1	72.7	73.6	↑	69.9
Access	Courtesy of registration staff	Press Ganey	74.5	75.3	79.1	79.6	77.7	77.9	78.2	79.9	82.1	81.0	80.8	80.9	↑	79.1
Access	Ease of contacting	Press Ganey	55.8	58.2	58.5	63.0	58.8	62.8	63.7	66.3	62.5	65.0	68.4	68.4	↑	62.9
Moving through your visit	Information about delays	Press Ganey	62.7	63.8	66.2	70.1	65.7	67.9	67.4	70.0	72.0	72.7	71.3	72.4	↑	68.9
Moving through your visit	Wait time at clinic	Press Ganey	58.6	60.8	64.6	64.6	61.8	62.8	65.2	66.1	67.5	67.2	67.7	69.5	↑	65.0
Moving through your visit	Staff worked together	Press Ganey	75.6	79.2	80.7	80.1	77.0	81.3	80.4	82.2	81.3	81.5	82.0	83.5	↑	80.5
LTR	LTR	Press Ganey	75.6	78.1	79.2	80.1	76.3	79.9	80.6	82.3	81.4	82.1	82.1	82.2	↑	80.2
LTR	**LTR CP**	Press Ganey	78.8	82.1	82.7	82.7	79.5	82.7	83.3	84.1	83.4	83.8	83.7	84.0	↑	82.7
LTR	LTR CP (telehealth only)	Press Ganey	77.1	81.9	85.5	74.0	83.0	75.0	76.8	86.1	81.8	74.8	87.5	74.6	↓	79.5

Questions on the survey

FY23 Point Change Improvement at Year End		
Frictionless Question	**Point Change Improvement**	**FYTD**
Staff worked together care for you (#1 key driver)	7.9	80.5
Ability to get desired appointment †	8.9	66.8
Ease of scheduling appointments	11.7	69.9
Ease of contacting	12.6	62.9
Courtesy of registration staff †	6.3	79.1
Information about delays	9.7	68.9
Wait time at clinic	10.9	65.0
Likelihood of recommending	6.6	80.2
Likelihood of recommending CP	5.2	82.7

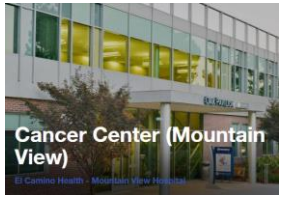
FYTD = 7/1/22-6/30/23

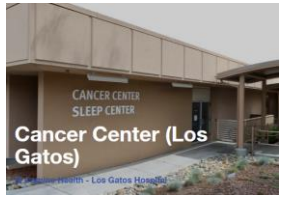
El Camino Health

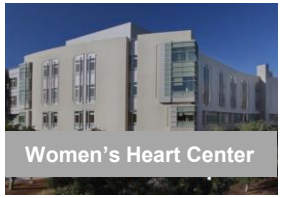
FY24

What is new for FY24?

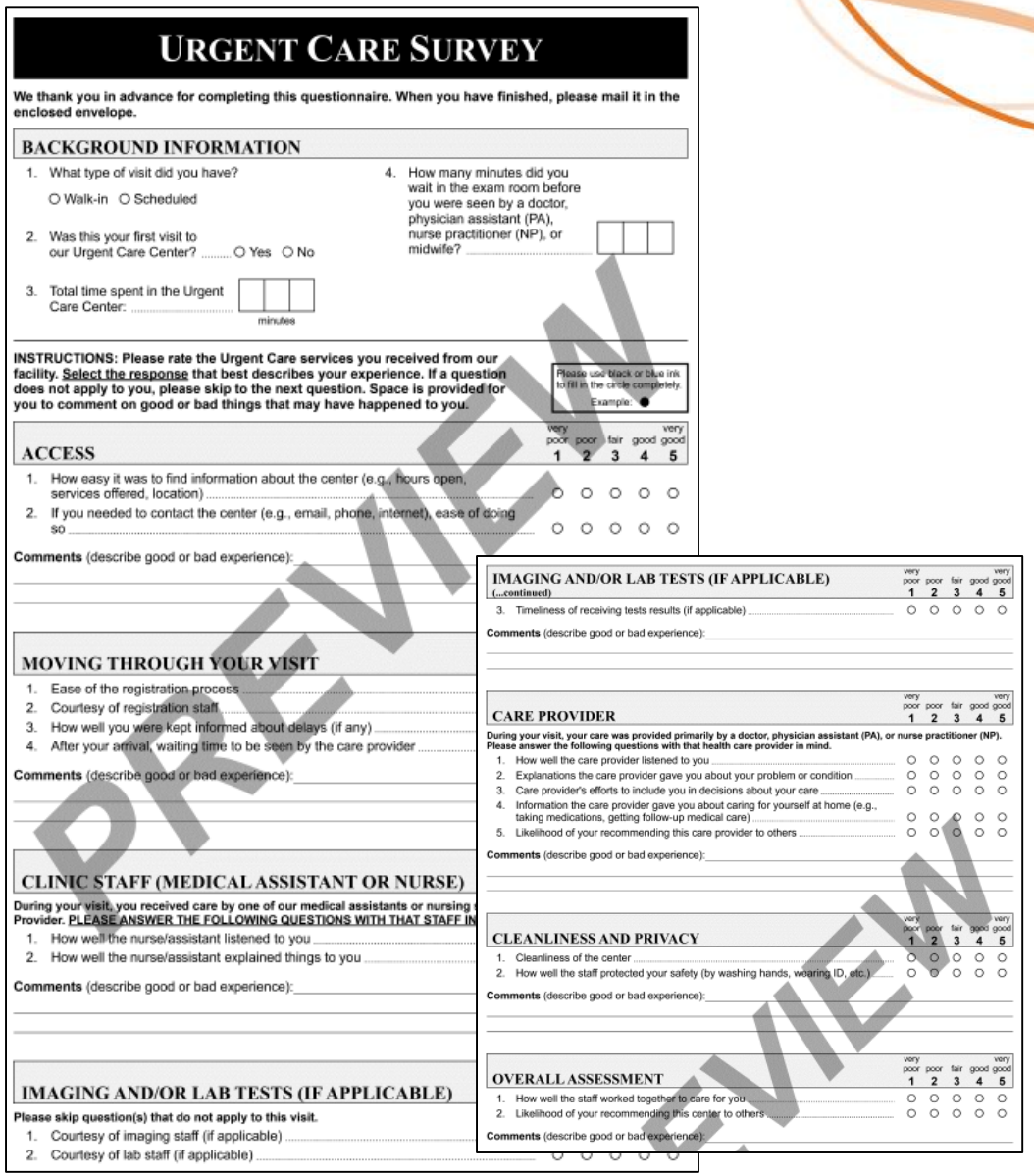
- Metric change from LTR CP (Likelihood to Recommend Care Provider) to **Likelihood to Recommend Clinic**
  - 3 hospital-based clinics added to Medical Practice Survey:







    - Pediatrics will fall under Primary Care specialty area
- Urgent Care moves to their own survey as of 7/1/23



URGENT CARE SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

BACKGROUND INFORMATION

1. What type of visit did you have? ○ Walk-in ○ Scheduled
2. Was this your first visit to our Urgent Care Center? ○ Yes ○ No
3. Total time spent in the Urgent Care Center: ___ minutes
4. How many minutes did you wait in the exam room before you were seen by a doctor, physician assistant (PA), nurse practitioner (NP), or midwife? ___

INSTRUCTIONS: Please rate the Urgent Care services you received from our facility. Select the response that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely. Example: ●

ACCESS (very poor 1 · poor 2 · fair 3 · good 4 · very good 5)

1. How easy it was to find information about the center (e.g., hours open, services offered, location)
2. If you needed to contact the center (e.g., email, phone, internet), ease of doing so

Comments (describe good or bad experience):

MOVING THROUGH YOUR VISIT

1. Ease of the registration process
2. Courtesy of registration staff
3. How well you were kept informed about delays (if any)
4. After your arrival, waiting time to be seen by the care provider

Comments (describe good or bad experience):

CLINIC STAFF (MEDICAL ASSISTANT OR NURSE)

During your visit, you received care by one of our medical assistants or nursing
Provider. PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THAT STAFF IN

1. How well the nurse/assistant listened to you
2. How well the nurse/assistant explained things to you

Comments (describe good or bad experience):

IMAGING AND/OR LAB TESTS (IF APPLICABLE)

Please skip question(s) that do not apply to this visit.

1. Courtesy of imaging staff (if applicable)
2. Courtesy of lab staff (if applicable)

IMAGING AND/OR LAB TESTS (IF APPLICABLE) (...continued)

3. Timeliness of receiving tests results (if applicable)

Comments (describe good or bad experience):

CARE PROVIDER

During your visit, your care was provided primarily by a doctor, physician assistant (PA), or nurse practitioner (NP). Please answer the following questions with that health care provider in mind.

1. How well the care provider listened to you
2. Explanations the care provider gave you about your problem or condition
3. Care provider's efforts to include you in decisions about your care
4. Information the care provider gave you about caring for yourself at home (e.g., taking medications, getting follow-up medical care)
5. Likelihood of your recommending this care provider to others

Comments (describe good or bad experience):

CLEANLINESS AND PRIVACY

1. Cleanliness of the center
2. How well the staff protected your safety (by washing hands, wearing ID, etc.)

Comments (describe good or bad experience):

OVERALL ASSESSMENT

1. How well the staff worked together to care for you
2. Likelihood of your recommending this center to others

Comments (describe good or bad experience):

PREVIEW

PREVIEW

El Camino Health

Proposed Fiscal Year 2024 Organizational Performance Goals – Draft 06/14/2023 for ECHB approval

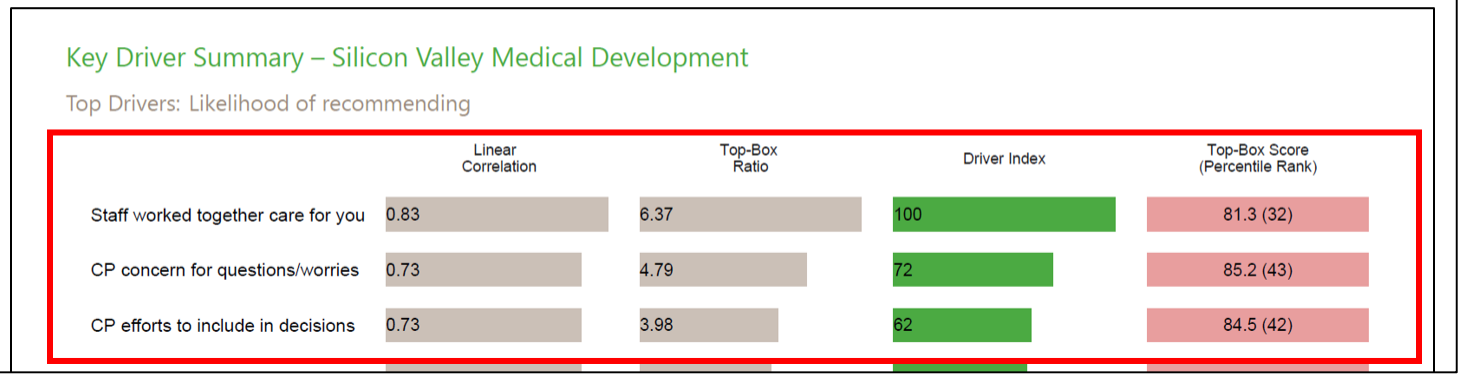
Pillar	Weight	OBJECTIVES/ OUTCOMES	Benchmark		Measurement Defined			Measurement Period
			Internal Benchmarks	External Benchmark	Minimum	Target	Stretch	
Threshold		Maintain positive EBIDA Margin	FY2020: 11.6%; FY2021: 15.8% FY2022 through March: 19.6% Budget FY2023: 16.7%	Moody's: Median for 'A1': 9.7% Median for 'Aa3': 8.9%	≥ 80% of budgeted Operating EBIDA Margin			FY2024
Quality and Safety	25%	HAC Index	FY2023 composite score	Benchmarked through CMS and Leapfrog metrics	2% improvement from FY2022 baseline	3% improvement from FY2022 baseline	4% improvement from FY2022 baseline	FY2024
Service	25% (Hospital)	Likelihood to Recommend (LTR) – Inpatient	FY2023 through March: 75.5 (81st % ile)	Press Ganey	Target minus distance between Target and Stretch	Target in line with top 50% of improvers	Target in line with top 30% of improvers	FY2024
	OR							
	25% (ECHMN)	Likelihood to Recommend (LTR) – ECHMN	FY2023 through March: 82.2 (28th % ile)	Press Ganey	Target minus distance between Target and Stretch	Target in line with top 50% of improvers	Target in line with top 30% of improvers	FY2024
People	25% (Managers)	Culture of Safety	FY2018: 4.04 FY2021: 3.96	2021 Nat. Avg. - 4.01 Targets based on statistically significant improvement	Methodology utilizes Press Ganey's statistical significance analysis for recommended targets			FY2024
	OR				TBD	TBD	TBD	
	25% (Employees)		Participation in Culture of Safety Survey	Press Ganey average participation-75%	77%	80%	83%	FY2024
Finance	25%	Operating EBIDA Margin	FY2023 YTD Q3: $173 Million	Moody's: Median for 'A1': 9.7% Median for 'Aa3': 8.9%	*95% of Budget* *$221M*	*100% of Budget* *$233M*	*105% of Budget* *$245M*	FY2024

FY24 ECHMN LTR Targets FINAL

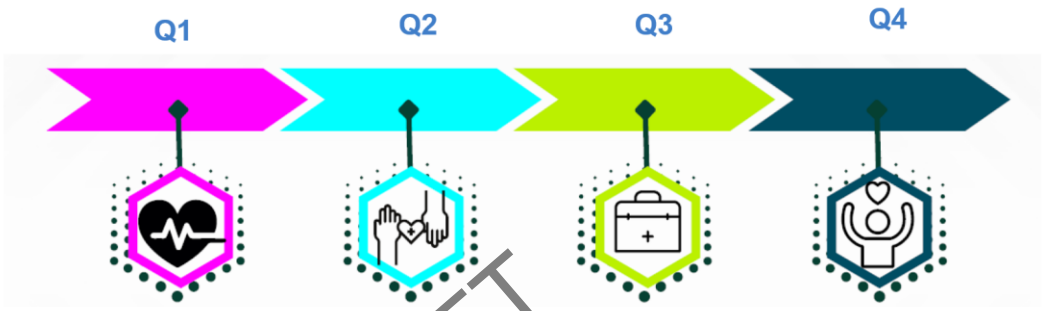
	FY23 Baseline	Target
LTR Clinic	80.7 27%ile	81.3 32%ile (+.58)
LTR Urgent Care	76.1 12%ile	78.0 68%ile (+1.89)

FY24 Plan

Key Drivers – what drives LTR?



FY24 Road Map



Q1
- Practicing Excellence (for MD's) Road Map
- Service Recovery Program for Staff
- Real Time Feedback
- Journey Mapping for Specialty Care and Surgery
- MyChart Activation Project
- Action of the Month – ease of contact
- Site / Clinic Action Plan post retreat
- E-Visit Launch
- Launch Provider Comments on website
- Urgent Care Survey Launch
- Key drivers by clinic

Q2
- WeCare Champions & coaching by role
- Website re-design
- Practicing Excellence (for MD's) Implementation
- Extend clinic hours in certain locations
- PDCA Provider Score Cards
- Physician shadowing
- Manager Leadership Development
- Expand Template Changes

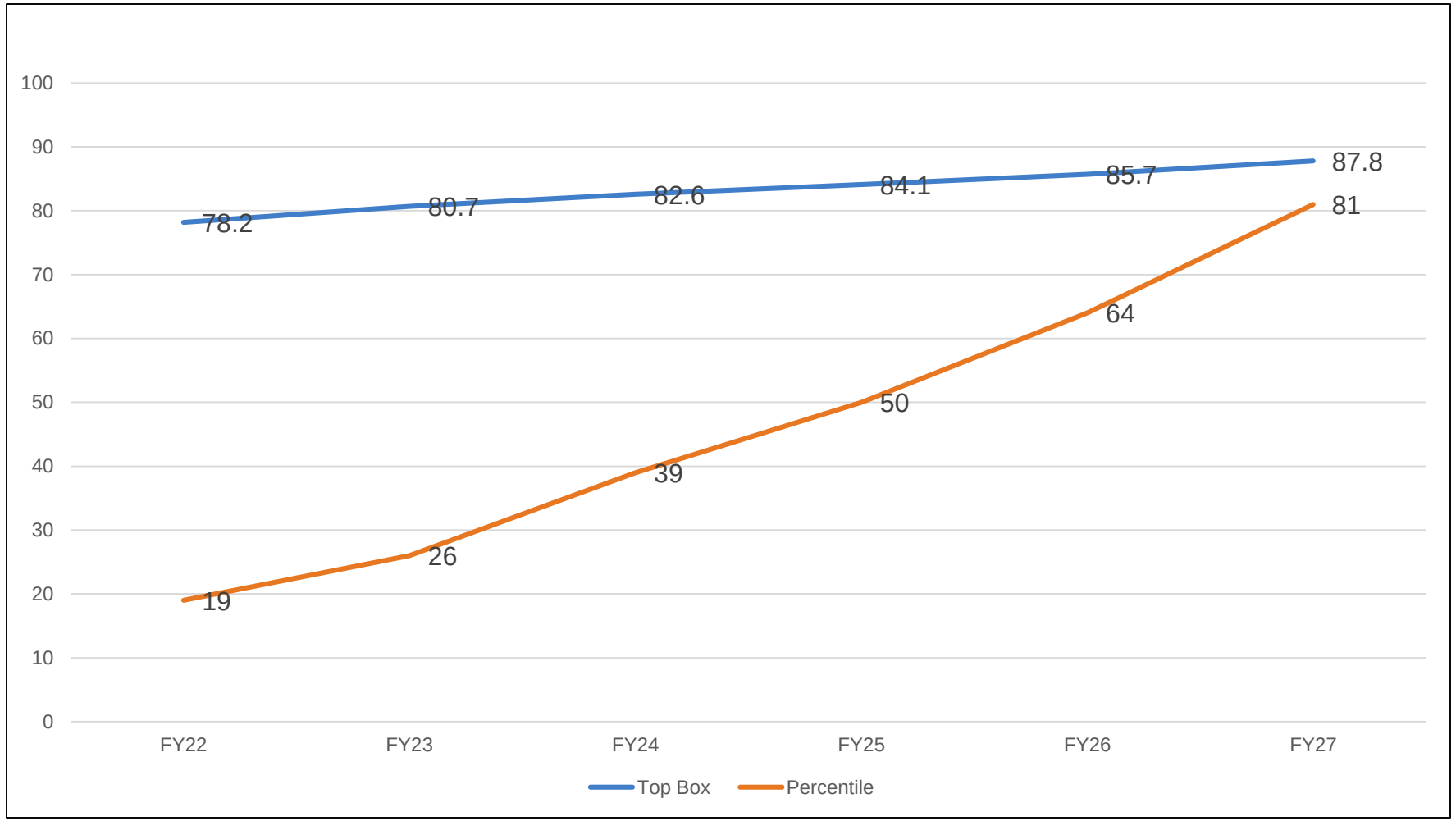
Q3
- Flu Shot Patient Communication Plan
- WeCare Video Vignettes
- Re-branding signage throughout ECHMN
- Adding digital display signage
- Provider cards and profiles
- Expand Fast Pass to 100%
- Review / expand office hours
- Direct line to referral team
- Arrival text message
- PDCA no show policy

Q4
- New Patient Packets
- Provider Patient Experience Retreat
- Patient Communication Plan and symptom checker
- Triage nurse at Call Center
- One ECH app
- Seamless video visit technology
- No establish care visit

DRAFT

Frictionless Experience Focus Area(s):	Action Steps	Who	Target Date
Criteria of Success/Goal:			
Frictionless Experience Focus Area(s):	**Action Steps**	**Who**	**Target Date**
Criteria of Success/Goal:			
Frictionless Experience Focus Area(s):	**Action Steps**	**Who**	**Target Date**
Criteria of Success/Goal:			

ECHMN Projections (LTR Clinic)

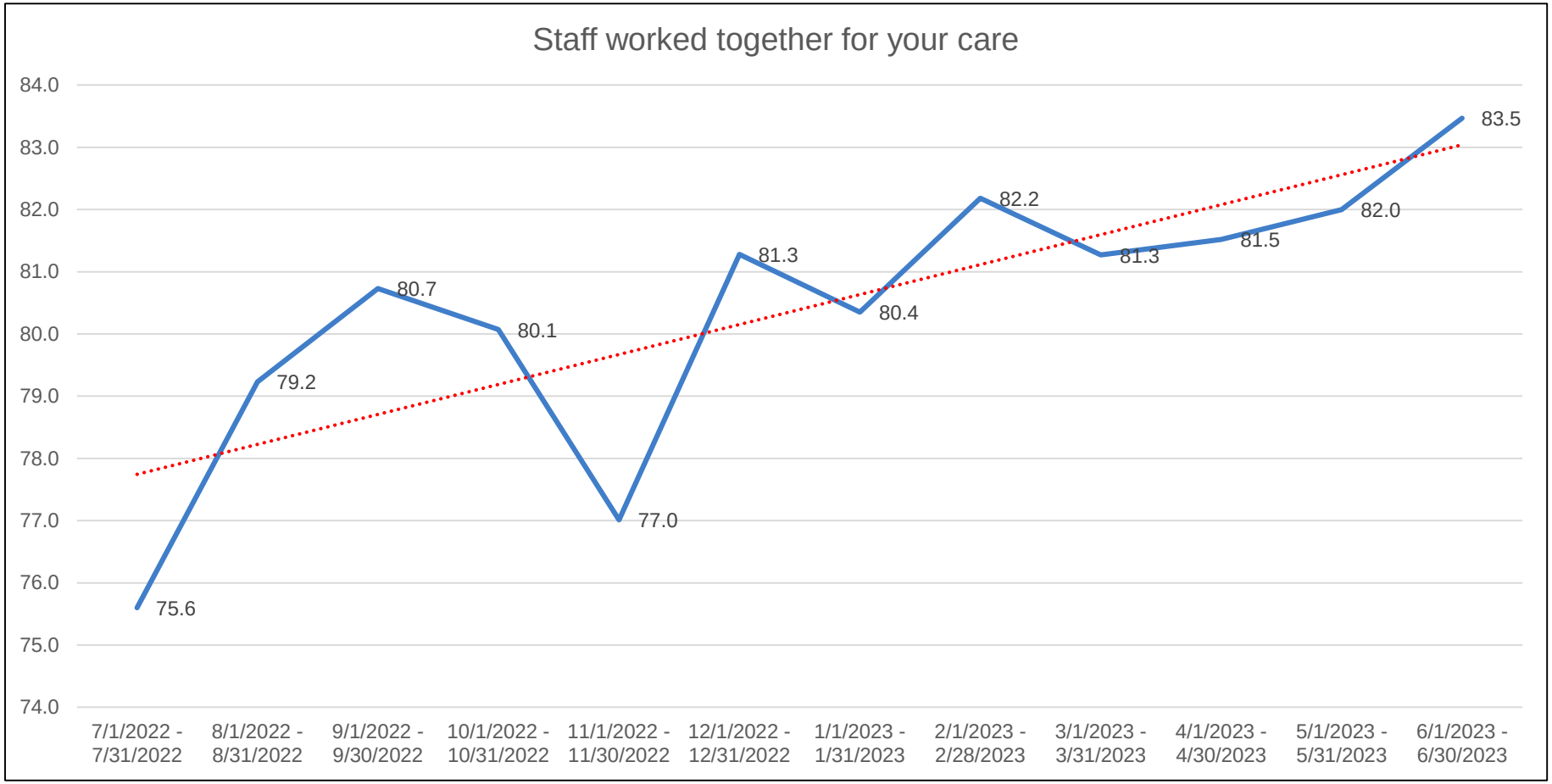


Questions

El Camino Health

Appendix

FY23 Outcomes

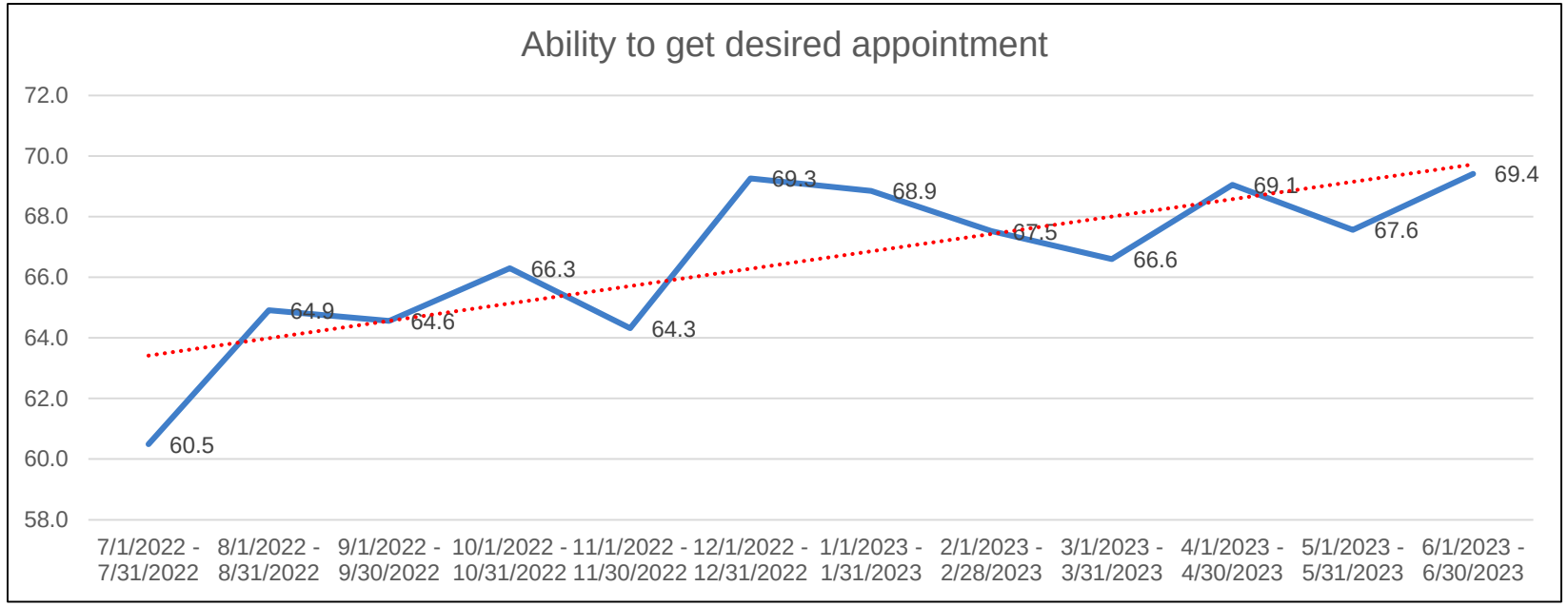


+7.9 points

#1 Key Driver

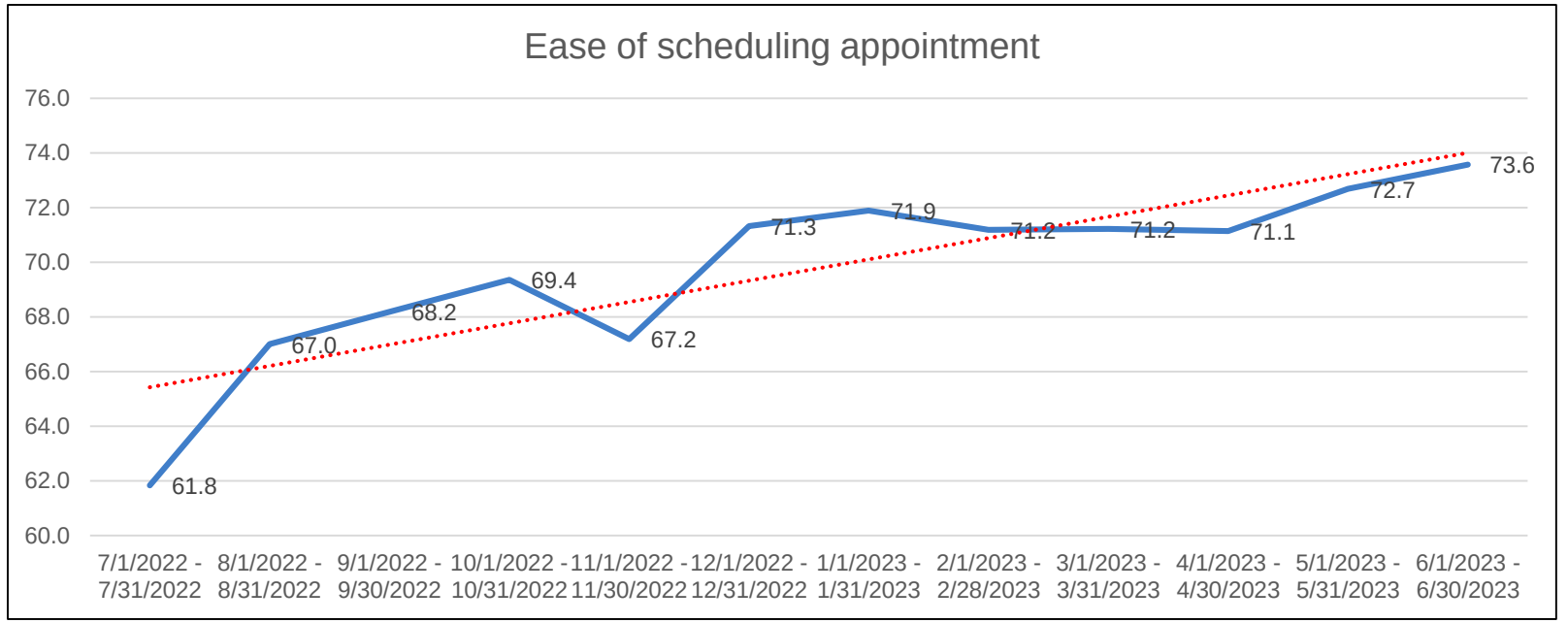
El Camino Health

FY23 Outcomes



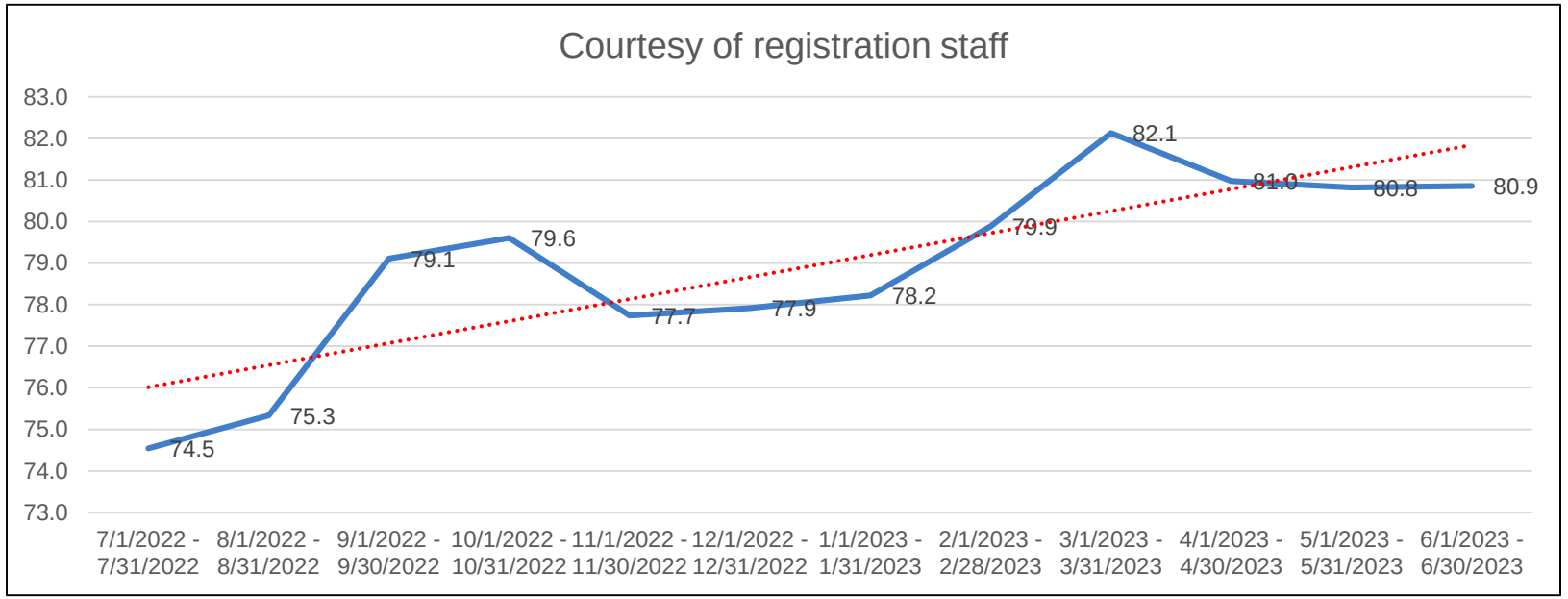
+8.9 points

+11.7 points



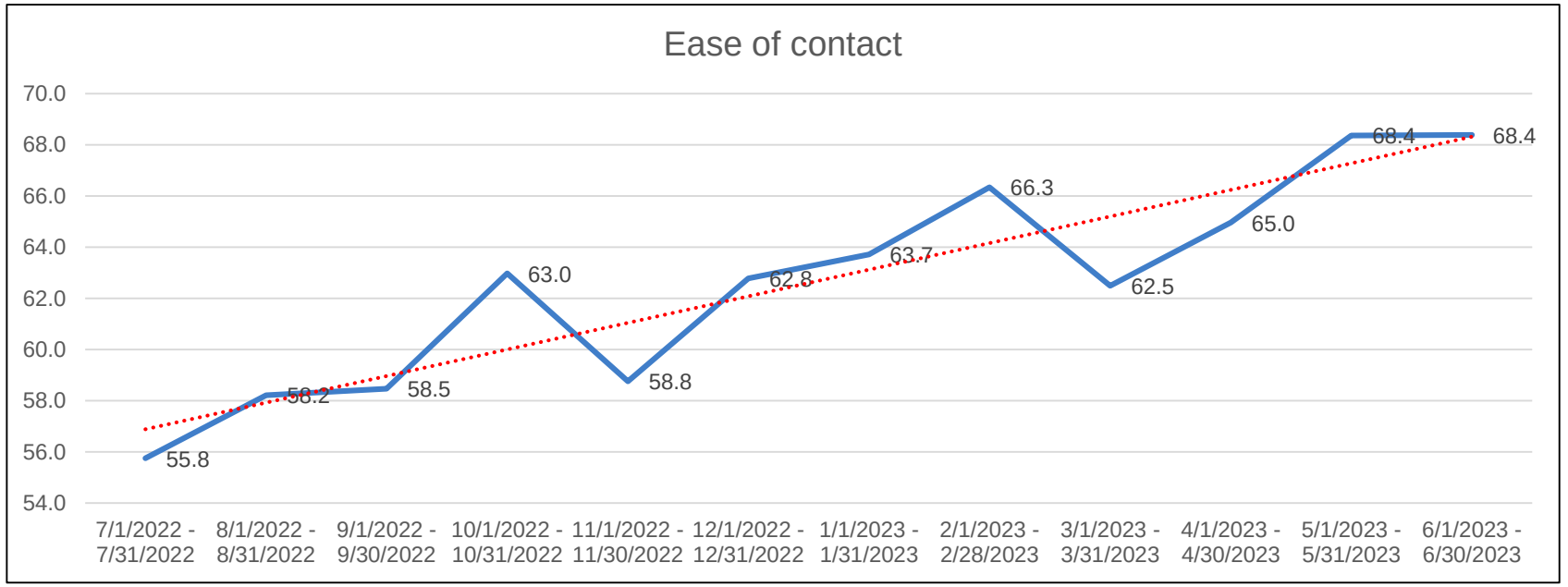
El Camino Health

FY23 Outcomes



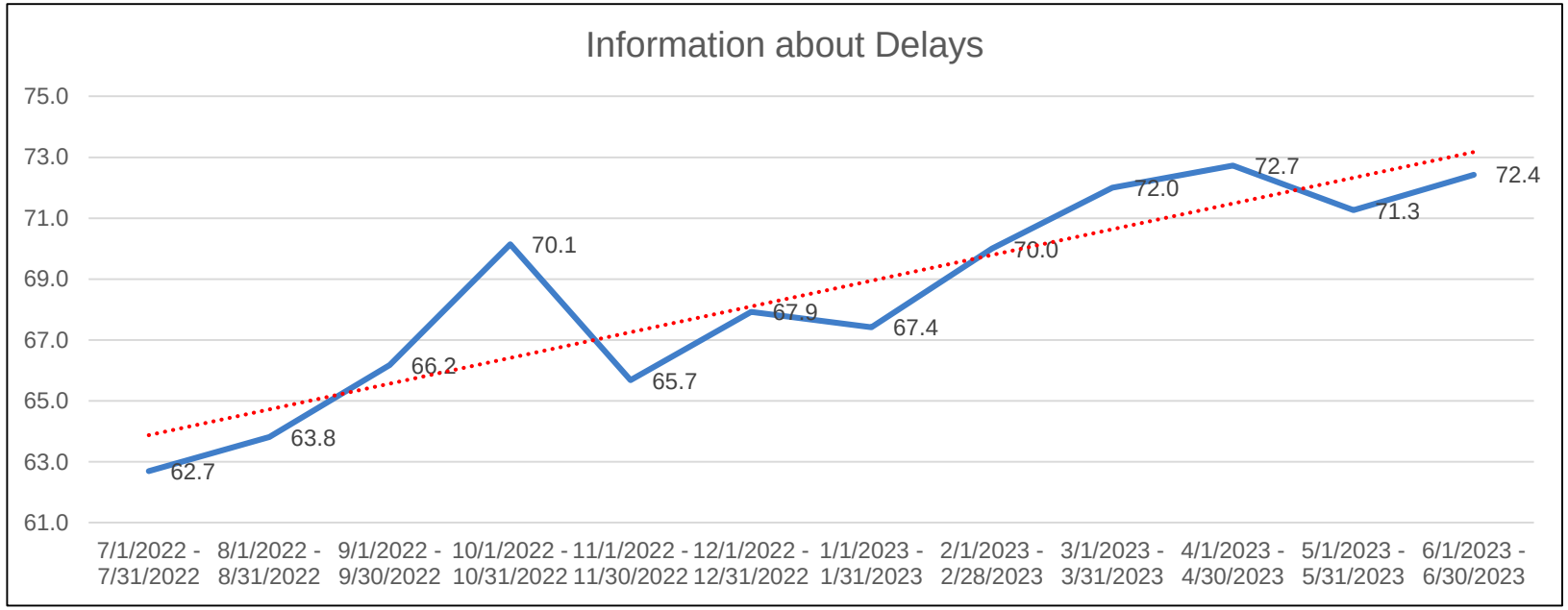
+6.3 points

+12.6 points



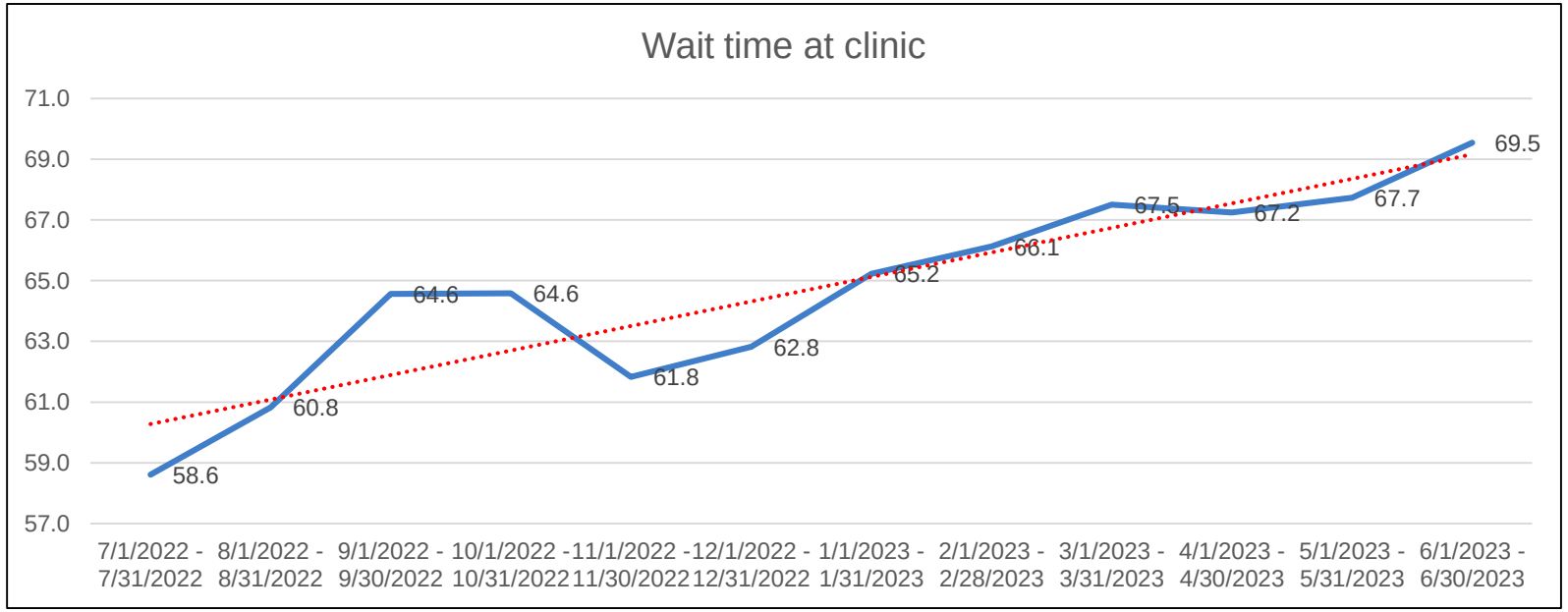
El Camino Health

FY23 Outcomes



+9.7 points

+10.9 points



El Camino Health

Summary of Response Distribution – LTR Clinic (with Urgent Care)

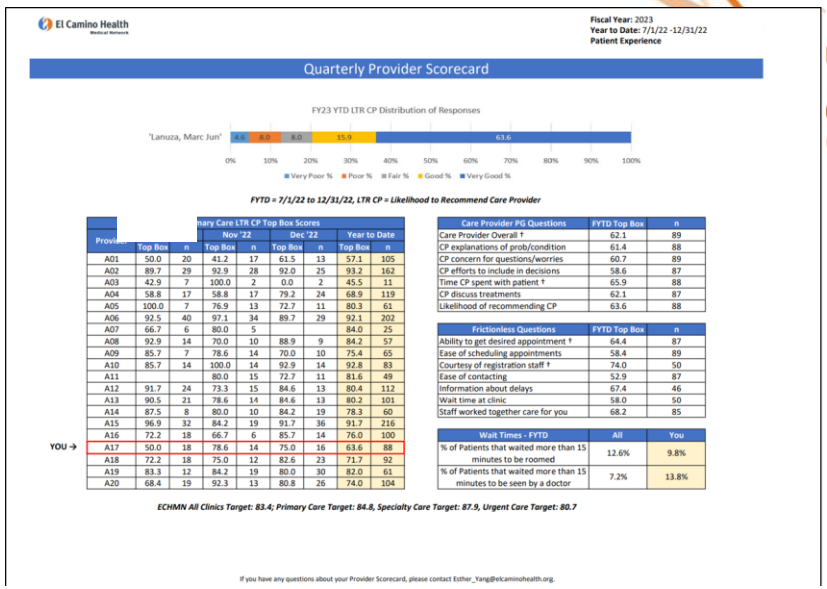
Specialty Area	FY23 YTD		FY23 Target
	% Top Box	% Very Good/ Good	
ECHMN - All	80.2	94.7	83.4
Primary Care	79.5	94.4	84.8
Specialty Care	82.2	96.0	89.7
Urgent Care	76.1	91.4	80.7

Green ≥ Target
Red < Target

FY23 YTD = 7/1/22 – 6/30/23

One on One Physician Coaching

- Multiple meetings / coaching for all low scoring providers
- Quarterly provider specific score card with comments, rankings, their scores (blinded vis a vis their peers)
- WeCare Coaching


El Camino Health

Fiscal Year: 2023
Year to Date: 7/1/22 -12/31/22
Patient Experience

Quarterly Provider Scorecard

FY23 YTD LTR CP Distribution of Responses

'Lanuza, Marc Jun'

Very Poor % Poor % Fair % Good % Very Good %

FYTD = 7/1/22 to 12/31/22, LTR CP = Likelihood to Recommend Care Provider

Provider	Nov '22 Top Box	Nov '22 n	Dec '22 Top Box	Dec '22 n	Year to Date Top Box	Year to Date n
A01	50.0	20	41.2	17	61.5	13	57.1	105
A02	89.7	29	92.9	28	92.0	25	93.2	162
A03	42.9	7	100.0	2	0.0	2	45.5	11
A04	58.8	17	58.8	17	79.2	24	68.9	119
A05	100.0	7	76.9	13	72.7	11	80.3	61
A06	92.5	40	97.1	34	89.7	29	92.1	202
A07	66.7	6	80.0	5			84.0	25
A08	92.9	14	70.0	10	88.9	9	84.2	57
A09	85.7	7	78.6	14	70.0	10	75.4	65
A10	85.7	14	100.0	14	92.9	14	92.8	83
A11			80.0	15	72.7	11	81.6	49
A12	91.7	24	73.3	15	84.6	13	80.4	112
A13	90.5	21	78.6	14	84.6	13	80.2	101
A14	87.5	8	80.0	10	84.2	19	78.3	60
A15	96.9	32	84.2	19	91.7	36	91.7	216
A16	72.2	18	66.7	6	85.7	14	76.0	100
YOU → A17	50.0	18	78.6	14	75.0	16	63.6	88
A18	72.2	18	75.0	12	82.6	23	71.7	92
A19	83.3	12	84.2	19	80.0	30	82.0	61
A20	68.4	19	92.3	13	80.8	26	74.0	104

ECHMN All Clinics Target: 83.4; Primary Care Target: 84.8, Specialty Care Target: 87.9, Urgent Care Target: 80.7

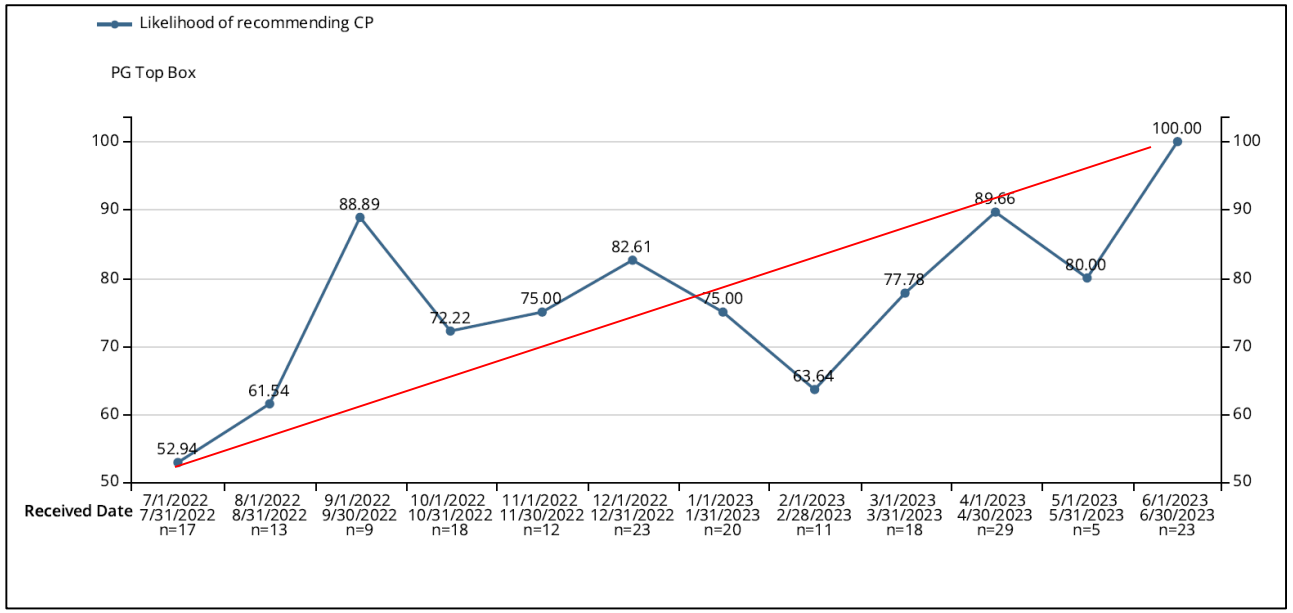
Care Provider PG Questions	FYTD Top Box	n
Care Provider Overall †	62.1	89
CP explanations of prob/condition	61.4	88
CP concern for questions/worries	60.7	89
CP efforts to include in decisions	58.6	87
Time CP spent with patient †	65.9	88
CP discuss treatments	62.1	87
Likelihood of recommending CP	63.6	88

Frictionless Questions	FYTD Top Box	n
Ability to get desired appointment †	64.4	87
Ease of scheduling appointments	58.4	89
Courtesy of registration staff †	74.0	50
Ease of contacting	52.9	87
Information about delays	67.4	46
Wait time at clinic	58.0	50
Staff worked together care for you	68.2	85

Wait Times - FYTD	All	You
% of Patients that waited more than 15 minutes to be roomed	12.6%	9.8%
% of Patients that waited more than 15 minutes to be seen by a doctor	7.2%	13.8%

If you have any questions about your Provider Scorecard, please contact Esther_Yang@elcaminohealth.org.

Progress!



Essential WeCare Behaviors for Care Providers

wecare

Our Service Excellence Standards

- W Warm Welcome
- e Engage with Empathy
- c Compassionate Communication
- a Ask and Anticipate
- r Respond Promptly
- e Excellence Always

Knock before entering patient room and ask if you may enter. Practice hand hygiene in front of patient and verbalize this step

Introduce yourself and your role. Keep badge visible.

Personalize the encounter by greeting patients by their name and asking for their preferred name.

Ensure conversation with patient and family cannot be overheard by others

Maintain eye contact: Communicate at patient level by sitting on a chair or stool. Be mindful of body language and tone of voice.

Be fully present. Listen intently without bias, don't interrupt, and allow patient to express concern fully.

Narrate care, explain what you are doing and "why"

Ask permission before start of any exam, tests or procedures

Confirm and verbalize understanding and set clear expectations on next steps

Before exiting, ask "what questions do you have for me" or "what else can I do for you?"

Build Trust: Speak positively about fellow team members and the organization

El Camino Health