El Camino Health

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

Monday, December 4, 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: 993 2561 0086#. No participant code. Just press #.

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

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Carol Somersille, MD Quality Committee Chair		**5:30 – 5:32 pm**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Carol Somersille, MD Quality Committee Chair	Possible Motion	**5:32 – 5:33**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair	Information	**5:33 – 5:34**
4.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. Written Public Comments *Comments may be submitted by mail to the El Camino Hospital Board Quality Committee at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	Carol Somersille, MD Quality Committee Chair	Information	**5:34 – 5:37**
5.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Carol Somersille, MD Quality Committee Chair	Motion Required	**5:37 – 5:42**
	a. Approve Minutes of the Open Session of the Quality Committee Meeting (11/06/2023) b. Approve Minutes of the Closed Session of the Quality Committee Meeting (11/06/2023) c. Receive Progress against FY24 Committee Goals			
6.	**VERBAL CHAIR'S REPORT**	Carol Somersille, MD Quality Committee Chair	Information	**5:42 – 5:47**

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

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
7.	**RECEIVE FY24 ENTERPRISE QUALITY DASHBOARD**	Holly Beeman, MD, MBA, Chief Quality Officer	Motion Required	**5:47 – 6:02**
8.	**RECEIVE FOLLOW UP ITEM - HAC 2.0 WEIGHTING**	Holly Beeman, MD, MBA, Chief Quality Officer	Motion Required	**6:02 – 6:12**
9.	**RECEIVE PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Motion Required	**6:12 – 6:22**
10.	**RECEIVE HEALTH EQUITY UPDATE**	Holly Beeman, MD, MBA, Chief Quality Officer	Motion Required	**6:22 – 6:37**
11.	**RECEIVE PSI REPORT**	Holly Beeman, MD, MBA, Chief Quality Officer	Motion Required	**6:37 – 6:47**
12.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**6:47 – 6:48**
13.	*Health and Safety Code section 32155 – reports of hospital medical quality assurance committee* **QUALITY COUNCIL MINUTES** a. Receive Quality Council Minutes (11/01/2023)	Carol Somersille, MD Quality Committee Chair	Discussion	**6:48 – 6:53**
14.	*Health and Safety Code Section 32155 and Gov't Code Section 54957 – Report regarding personnel performance of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance committee* **APPROVE CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer	Motion Required	**6:53 – 7:03**
15.	*Health and Safety Code Section 32155 –* reports of hospital quality assurance committee **VERBAL SERIOUS SAFETY/RED ALERT EVENT REPORT**	Holly Beeman, MD, MBA, Chief Quality Officer	Discussion	**7:03 – 7:08**
16.	*Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management:* **EXECUTIVE SESSION**	Carol Somersille, MD Quality Committee Chair	Discussion	**7:08 – 7:18**
17.	**RECONVENE OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:18 – 7:19**
18.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:19 – 7:20**
19.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Information	**7:20 – 7:24**
20.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:24 – 7:25 pm**

Next Meeting: 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, November 6, 2023
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent	Others Present
Carol Somersille, MD	**Prithvi Legha,** MD	**Holly Beeman,** MD, MBA, CQO
Krutica Sharma, MD (*at 5:34 p.m.*)		**Dan Woods,** CEO **
Melora Simon		**Mark Adams,** MD, CMO
John Zoglin		**Christine Cunningham**, Chief Experience and Performance Improvement Officer
Pancho Chang		**Shahab Dadjou**, ECHMN President
Jack Po, MD (*at 5:32 p.m.*)		**Ute Burness**, ECHMN VP of Quality and Payer Relations
Philip Ho, MD (*at 6:05 p.m.*)		**Cheryl Reinking,** DPN, RN, CNO
		Shreyas Mallur, MD, ACMO
		Deb Muro, CIO **
		Ken King, CASO **
		Nicole Silva, ECHMN COO
		Lyn Garrett, Senior Director, Quality
		Nicole Hartley, Executive Assistant II
	**via teleconference	**Gabriel Fernandez,** Coordinator, Governance Services

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Health (the "Committee") was called to order at **5:31 p.m.** by Chair Carol Somersille. A verbal roll call was taken. Committee members Jack Po, Krutica Sharma, Prithvi Legha, and Phillip Ho were absent from the roll call. All other members were present at the roll call and participated in person. A quorum was not present until Jack Po arrived at **5:32 p.m.** Krutica Sharma arrived at **5:34 p.m.** and Phillip Ho arrived at **6:05 p.m**. No votes were taken on any items until after Committee Member Po's arrival.	Call to order at **5:31 p.m.**
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	No members of the Committee participated remotely and no AB 2449 requests were submitted.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
4. PUBLIC COMMUNICATION	There were no comments from the public.	

5. CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. **Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (09/05/2023), (b) Minutes of the Closed Session of the Quality Committee Meeting (09/05/2023), Received: (c) FY24 Pacing Plan, (d) CDI Dashboard, (e) Core Measures **Movant**: Po **Second**: Simon **Ayes**: Somersille, Chang, Simon, Zoglin, Po **Noes**: None **Abstain**: None **Absent**: Sharma, Legha, Ho **Recused**: None	***Consent Calendar Approved***
6. VERBAL CHAIR'S REPORT	Chair Somersille made encouragements to the committee to be vocal within the Quality committee meetings and share their opinions given the extensive wealth of knowledge and experience of the members of the committee. Additionally, Chair Somersille asked, to continue to focus on the overarching goal and mission of the Quality Committee, for committee members who submit questions ahead of committee meetings to evaluate the nature of their questions before submitting. Chair Somersille asked that the nature of the questions be evaluated as to be for governance purposes and not questions looking into the day-to-day managerial process of the organization. In addition to these requests, Chair Somersille asked that committee members attempt to limit to five (5) questions or less, if possible but did express gratitude for the committee's commitment to thoroughly reviewing the materials before the meetings.	

7. PATIENT STORY	Cheryl Reinking, DPN, RN, CNO, provided a Patient Story report which was a letter from the mother of a patient in the community. Ms. Reinking discussed the great effort to coordinate the patient's care at the end of life. The family of the patient spoke about the moving and memorable nature of the honor walk done for this patient. Ms. Reinking emphasized the importance of a dignified and caring end-of-life ritual which facilitates leaving a lasting, positive impression on all the family members and loved ones of the patient. **Motion**: To receive the Patient Story report **Movant**: Simon **Second**: Chang **Ayes**: Somersille, Chang, Po, Sharma, Simon, Zoglin, **Noes**: None **Abstain**: None **Absent**: Legha, Ho **Recused**: None	
8. SAFETY REPORT FOR THE ENVIRONMENT OF CARE	Ken King, CASO, delivered the Annual Safety Report for The Environment of Care. Mr. King discussed the various training events and decreases in reportable injuries across the organization. Mr. King attributed an emphasis to the 'Safety First, Mission Zero' initiative has translated to these improved results. Mr. King also attributed improvements in Emergency Management preparation to the addition of a new Manager of Emergency Management. **Motion**: To receive the Annual Safety Report for the Environment of Care **Movant**: Sharma **Second**: Po **Ayes**: Somersille, Chang, Po, Sharma, Simon, Zoglin, **Noes**: None **Abstain**: None **Absent**: Legha, **Recused**: None	***Actions:*** *ECHMN Staff to provide a report on their process for safety reporting procedures and oversight within the Medical Network*

9. EL CAMINO HEALTH MEDICAL NETWORK REPORT	Mr. Shahab Dadjou, Ms. Ute Burness, and Ms. Nicole Silva delivered the El Camino Health Medical Network Report. Ms. Burness highlighted the Core Quality measures results for Calendar Year 2023 and that for five (5) of these measures, the Medical Network ranks in the top 20% of the nation. Mr. Dadjou highlighted the improvements made by the Medical Network for key areas within the core measures. Ms. Silva discussed the Dependable and Convenient care results. Ms. Silva discussed the positive strides to reach target goals through recent recruiting and hiring practices. **Motion**: To receive the El Camino Health Medical Network Report **Movant**: Po **Second**: Simon **Ayes**: Somersille, Chang, Ho, Po, Sharma, Simon, Zoglin, **Noes**: None **Abstain**: None **Absent**: Legha, **Recused**: None	
10. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session at 6:15 p.m. **Movant**: Chang **Second**: Simon **Ayes**: Somersille, Chang, Ho, Po, Sharma, Simon, Zoglin, **Noes**: None **Abstain**: None **Absent**: Legha, **Recused**: None	***Adjourned to closed session at 6:15 p.m.***
11. AGENDA ITEM 18: CLOSED SESSION REPORT OUT	During the closed session, the Quality Committee approved the recommendation of the Credentialing and Privileges Report for approval by the El Camino Hospital Board of Directors, by a unanimous vote of all members present.	
12. AGENDA ITEM 19: COMMITTEE ANNOUNCEMENTS	The committee discussed potentially actionable items from the meeting. No further commentary was provided.	

13. AGENDA ITEM 20: ADJOURNMENT	**Motion**: To adjourn at 7:06 p.m. **Movant**: Chang **Second**: Sharma **Ayes**: Somersille, Chang, Ho, Po, Sharma, Simon, Zoglin, **Noes**: None **Abstain**: None **Absent**: **Recused**: None	***Adjourned at 7:06 p.m.***

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

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Gabriel Fernandez, Governance Services Coordinator

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

El Camino Health

FY24 COMMITTEE GOALS

Quality, Patient Care, and Patient Experience Committee

PURPOSE

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

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

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

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

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

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: December 4, 2023
Subject: Enterprise Quality, Safety and Experience Dashboard through October 2023

Purpose:

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

Summary:

Situation: The Fiscal Year 2024 Enterprise Quality, Safety, and Experience dashboard is used throughout the organization to illustrate, track, and communicate a key set of metrics to align the quality, safety, and experience improvement work. This dashboard is produced monthly and includes trend lines and rolling 12-month average graphs.

Background: A detailed memo supporting the measures on the STEEEP and Enterprise Quality, Safety and Experience dashboard provided in depth analysis of performance, process improvement initiatives and timelines for the November 6th Quality Committee meeting. Many of the measures and impacts of interventions do not change notably in three weeks' time (the time of the writing of this memo). This dashboard memo will capture areas of notable interest compared to the last reporting three weeks ago, and not repeat what has already been reviewed and shared during the November 6, 2023, Committee meeting.

Assessment:

a) Quality Measures

i) **Hospital Acquired Condition Index 2.0** (lower is better). This metric is a composite of the weighted rates of 4 component measures. The table below demonstrates FY23 baseline; # events, rate, weighted rate, and the HAC 2.0 Index baseline (1.453).

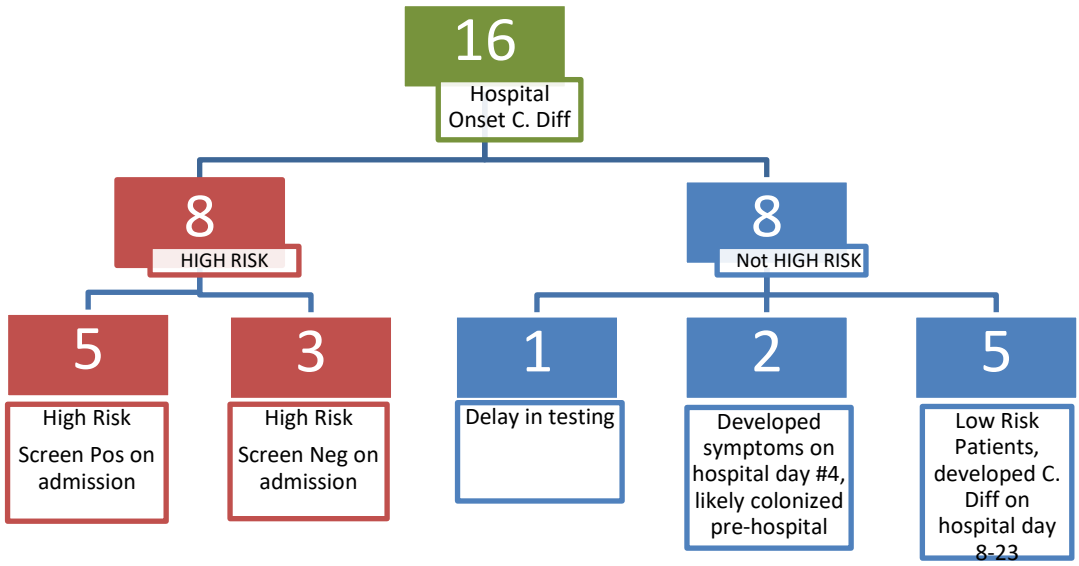
FY23 Baseline	Numerator	Denominator	Multiplier per National Healthcare Safety Network (NHSN) guidelines *	FY23 Rate	FY24 Weighting	Weighted Rate
CAUTI	13	# catheter days	x 1,000	0.68	15%	0.103
CLABSI	8	# central line days	x 1,000	0.62	15%	0.093
C Diff	35	# patient days	x 10,000	3.32	35%	1.162
nvHAP	20	# patient days	x 1,000*	0.27	35%	0.096
					FY23 Baseline HAC Index	**1.453**
* nvHAP criteria not defined by NHSN					**Target 3% Reduction**	**1.410**

The HAC Index 2.0 for the month of October is 2.023 unfavorable to target of 1.410. Year to date the performance of 1.401 is favorable to target. The October performance

is due to a spike in C. Diff infections, 5 for the month. CLABSI, CAUTI, and nvHAP are on track and within the expected range for our target. There have been zero CLABSI infections in FY24 year to date. It has been 31 days since the last CAUTI infection, as of November 27, 2023. There was a single nvHAP infection in the month of October.

There have been 16 C. Difficile infections in FY24 through October 2023. This is three more than this time in FY23. The root causes for the current C. Diff infections differs from the conditions in FY23, delayed testing, which resulted in many of the FY23 infections being considered hospital onset, when in fact, patients had C. Diff undiagnosed due to a delay in sending stool to the lab for testing without delay from the onset of symptoms. Of the sixteen C. Diff infections in FY24, only one, is due to a delay in sending the stool sample timely. In FY23 five of the thirteen hospital onset cases were due to a delay in sending the stool sample within the first three days of hospitalization if the patient has symptoms.

The chart below illustrates the focused review findings of each case of hospital onset C. Difficile infection and informs our process improvement priorities.



- For the three high risk patients who screened negative on admission, we are reviewing conformity with standard practice on how to accurately collect the screening peri-anal c. difficile screening sample.
- Although consistency with timely stool sample collection for patients with symptoms has improved significantly, we need to ensure we refresh the training on a regular cadence. This is important as the winter season is upon us when we rely on travel nurses for our surge planning.

- The five low risk patients who acquired C. difficile during their hospitalization on days 8-23 of hospitalization can likely be avoided through improved hand hygiene, and consistent environmental cleaning procedures.

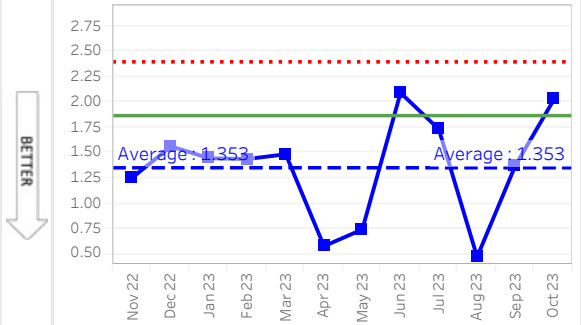
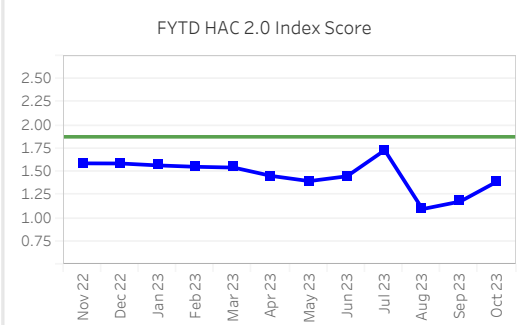
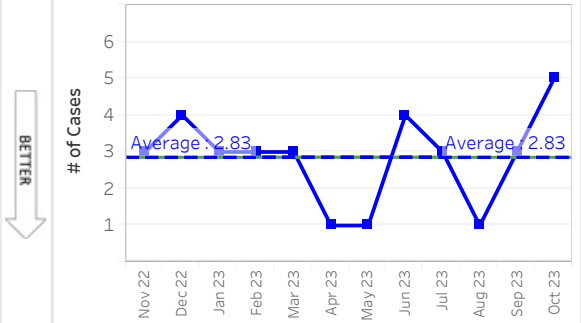
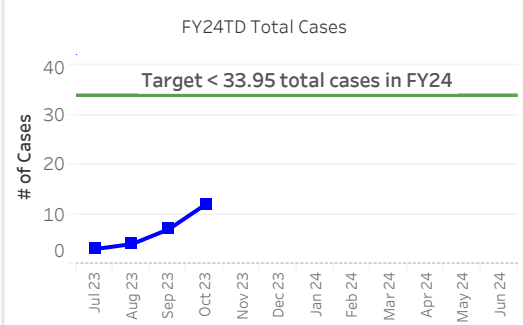
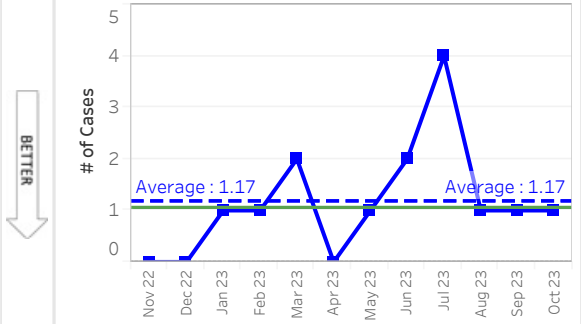
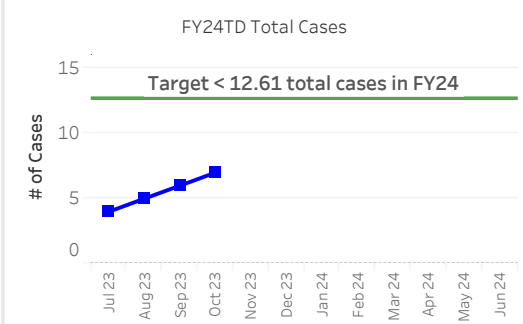
Attachment: FY24 Enterprise Quality, Safety, and Experience Dashboard

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

October 2023 (unless other specified)

Month to Board Quality Committee : December 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal HAC Index 2.0 Latest Month : October 2023	2.023	1.401	1.453	1.410 (3.0% ↓)		
HAC Component Clostridium Difficile Infections (C-Diff) Latest Month : October 2023	5 cases	3.00 cases/mo	2.92 cases/mo	2.83 cases/mo		
HAC Component Catheter Associated Urinary Tract Infection (CAUTI) Latest Month : October 2023	1 cases	1.75 cases/mo	1.08 cases/mo	1.05 cases/mo		

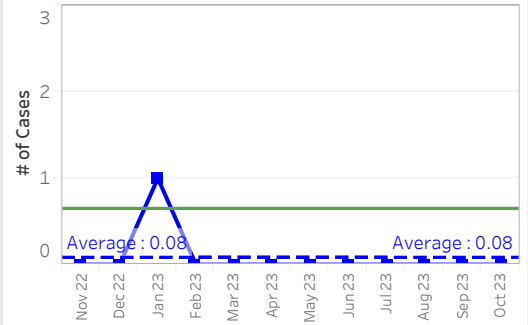
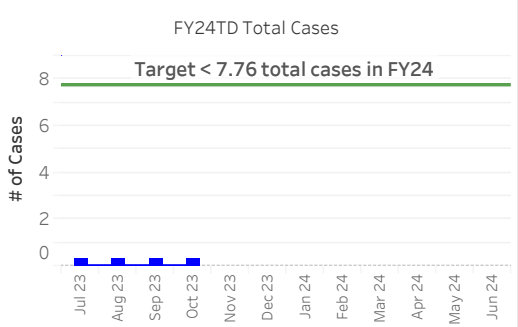
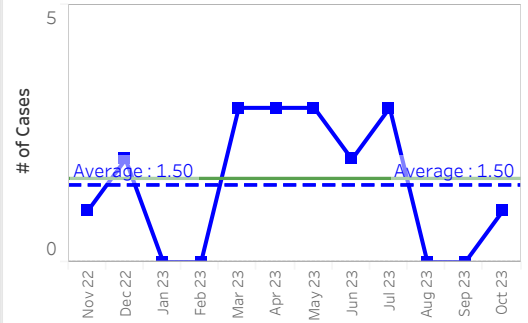
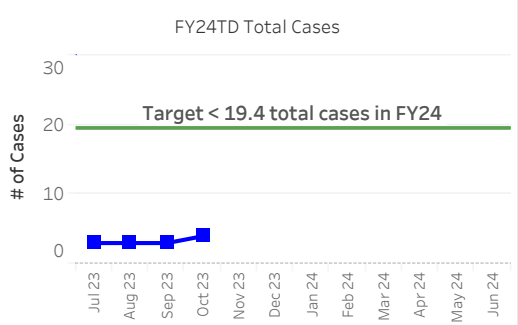
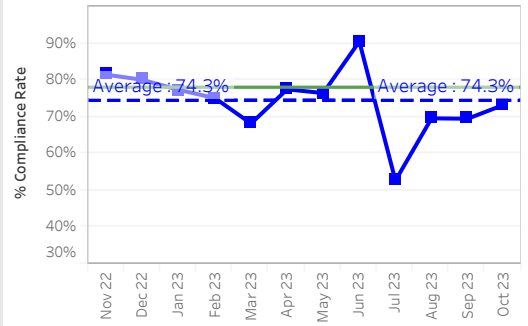
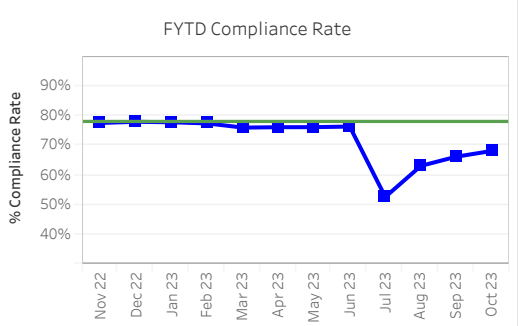
Quality Department | Note : updated as of November 21, 2023

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

October 2023 (unless other specified)

Month to Board Quality Committee : December 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
HAC Component Central Line Associated Blood Stream Infection (CLABSI) Latest Month : October 2023	0 cases	0.00 cases/mo	0.67 cases/mo	0.65 cases/mo		
HAC Component non-ventilator Hospital-Acquired Pneumonia (nvHAP) Latest Month : October 2023	1 cases	1.00 cases/mo	1.67 cases/mo	1.62 cases/mo		
Hand Hygiene (Entry) Compliance % Latest Month : October 2023	73.3%	68.3%	76.5%	78.0%		

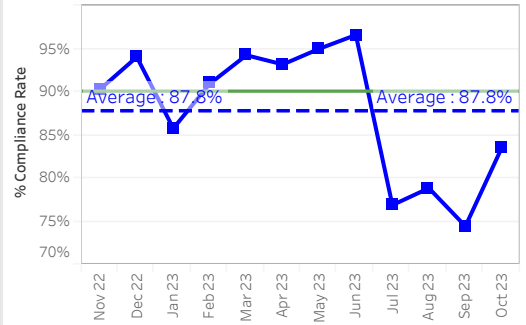
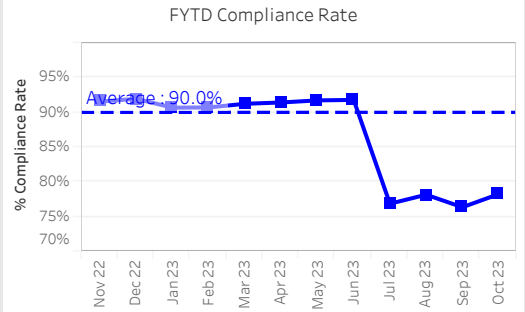
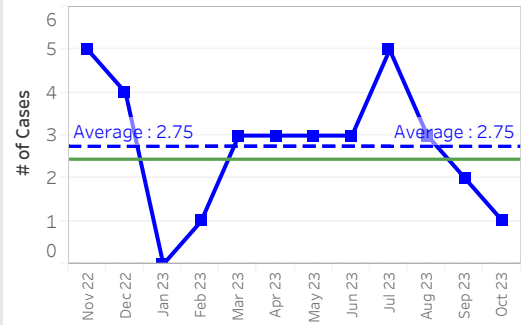
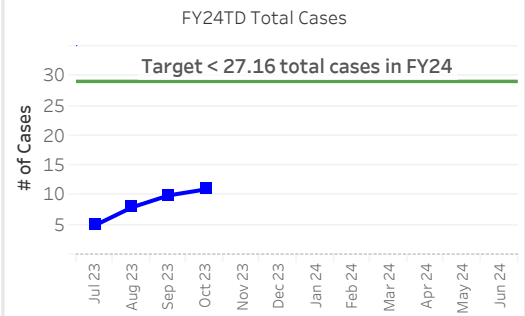
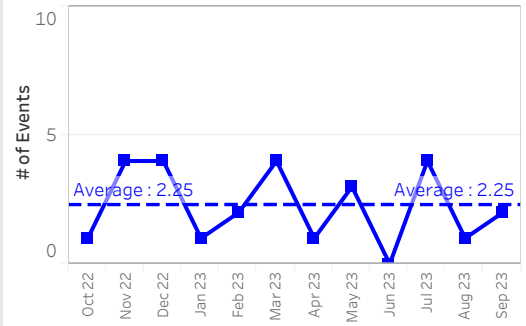
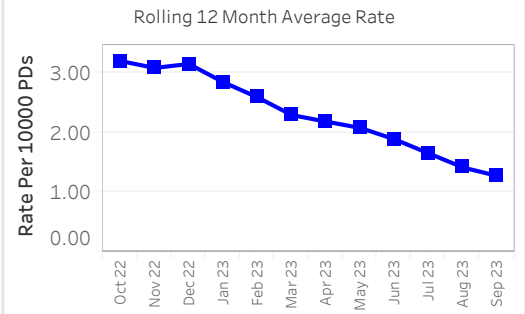
Quality Department | Note : updated as of November 21, 2023

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

October 2023 (unless other specified)

Month to Board Quality Committee : December 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Hand Hygiene (Exit) Compliance % Latest Month : October 2023	83.6%	78.3%	91.8%	90.0%		
Surgical Site Infections (SSI) Latest Month : October 2023	1 cases	2.75 cases/mo	2.50 cases/mo	2.42 cases/mo		
Serious Safety Event Rate (SSER) Latest Month : September 2023	2 events	1.33 (7 / 52444)	1.88 (40 / 212460)	n/a		

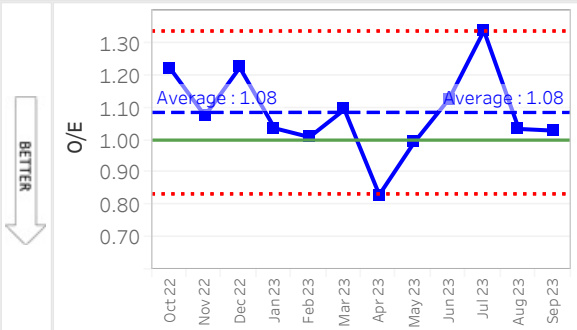
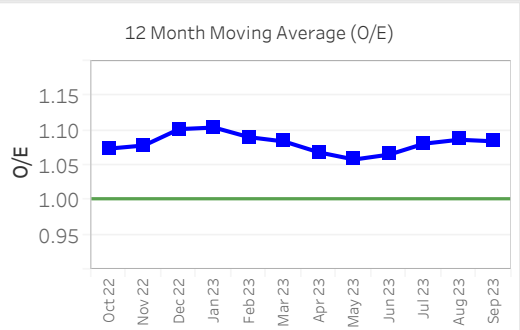
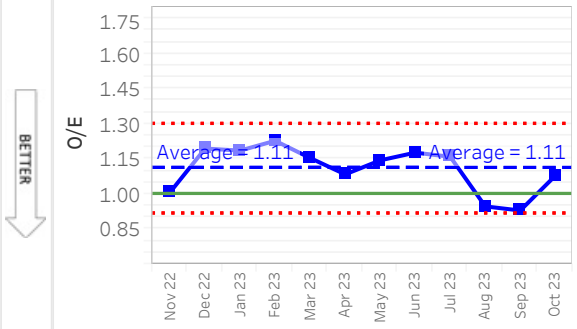
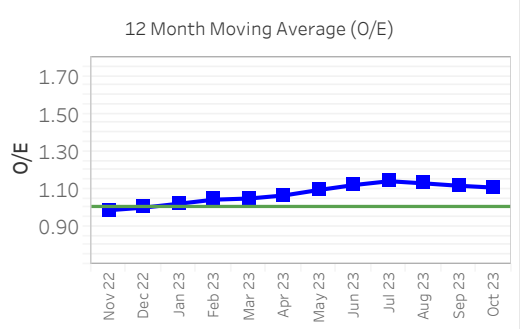
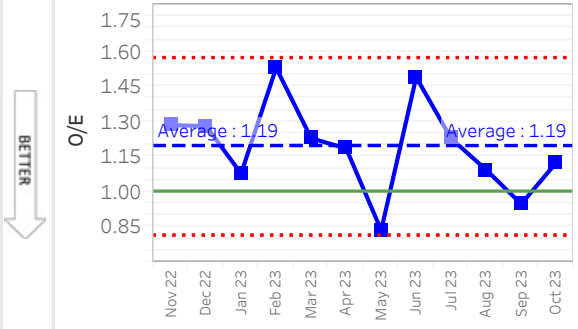
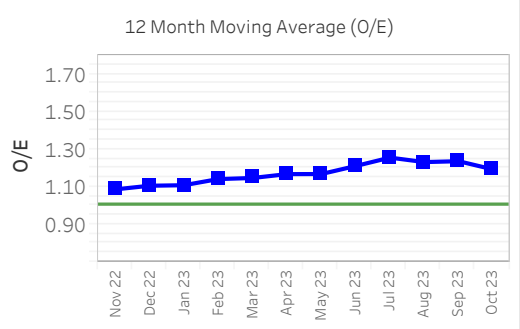
Quality Department | Note : updated as of November 21, 2023

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

October 2023 (unless other specified)

Month to Board Quality Committee : December 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Readmission Index (All Patient All Cause Readmit) Observed / Expected Premier Care Sciences Standard RA Latest Month : September 2023	1.03 (7.94% / 7.72%)	1.13 (9.16% / 8.08%)	1.07 (8.47% / 7.94%)	1.00		
Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : October 2023	1.08 (1.94% / 1.80%)	1.02 (1.89% / 1.85%)	1.13 (2.21% / 1.96%)	1.00		
Sepsis Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : October 2023	1.12 (10.90% / 9.69%)	1.08 (11.78% / 10.88%)	1.21 (14.07% / 11.59%)	1.00		

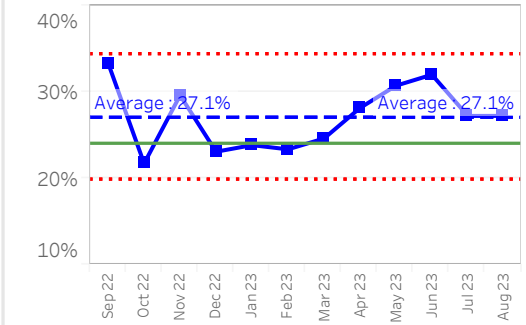
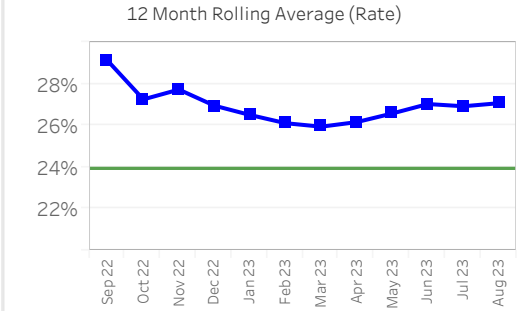
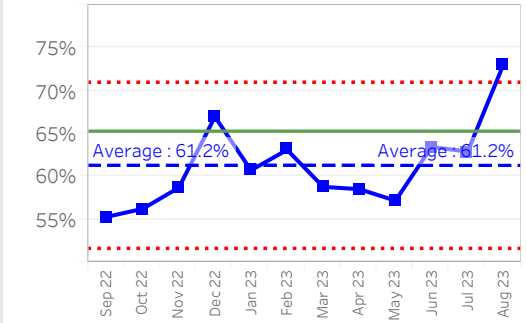
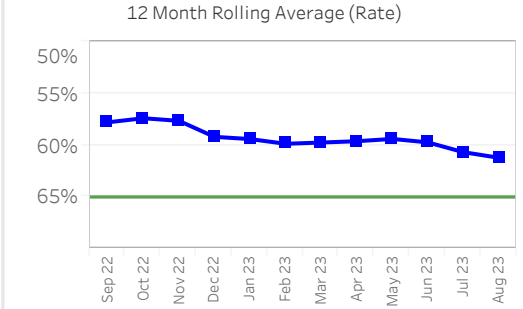
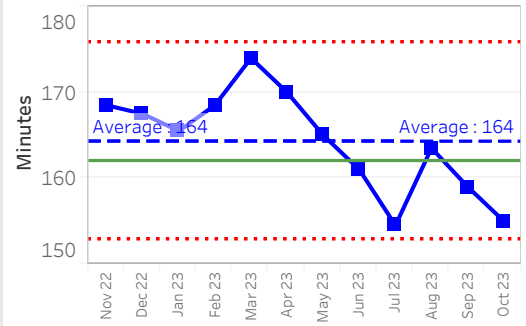
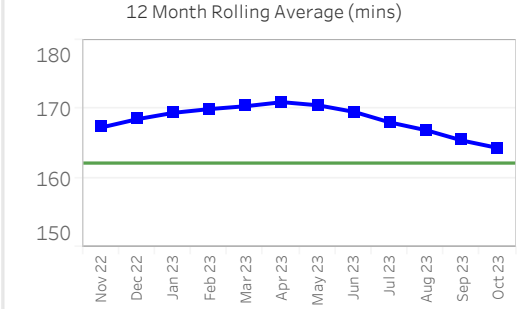
Quality Department | Note : updated as of November 21, 2023

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

October 2023 (unless other specified)

Month to Board Quality Committee : December 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend		FYTD or Rolling 12 Month Average
	Latest Month	FYTD					
PC-02 : Cesarean Birth	MV : 29.4% (52 / 177)	MV : 29.4% (52 / 177)	MV : 28.1% (530 / 1883)	23.9% (FY24 ENT Target)	BETTER		BETTER	
Latest Month : August 2023	LG : 12.0% (3 / 25)	LG : 12.0% (3 / 25)	LG : 20.1% (65 / 323)				
	ENT : 27.2% (55 / 202)	ENT : 27.2% (55 / 202)	ENT : 27.0% (595 / 2206)				
PC-05 : Exclusive Breast Milk Feeding	MV : 70.5% (215 / 305)	MV : 70.5% (215 / 305)	MV : 58.1% (1966 / 3385)	65.1% (FY24 ENT & MV Target) 70.0% (FY24 LG Target)	BETTER		BETTER	
Latest Month : August 2023	LG : 91.1% (41 / 45)	LG : 91.1% (41 / 45)	LG : 68.3% (427 / 625)				
	ENT : 73.1% (256 / 350)	ENT : 73.1% (256 / 350)	ENT : 59.7% (2393 / 4010)				
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)	MV : 177 mins	MV : 182 mins	MV : 197 mins	MV : 191 mins	BETTER		BETTER	
Latest Month : October 2023	LG : 133 mins	LG : 133 mins	LG : 142 mins	LG : 133 mins			
	ENT : 155 mins	ENT : 158 mins	ENT : 170 mins	ENT : 162 mins			

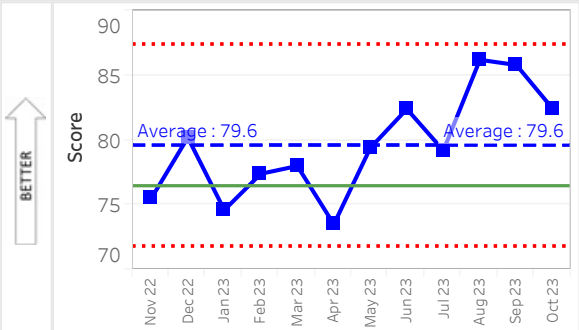
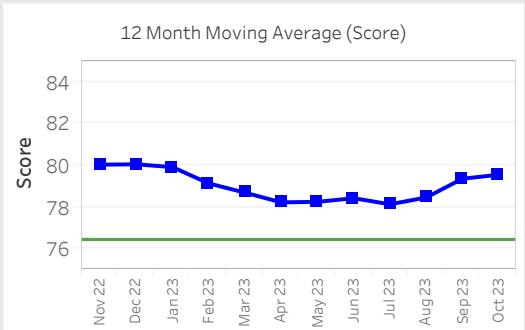
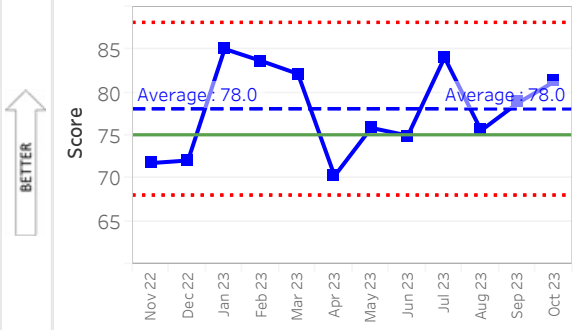
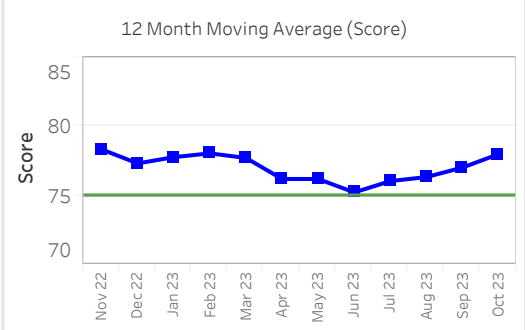
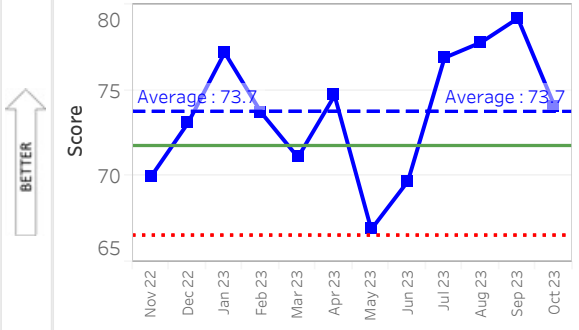
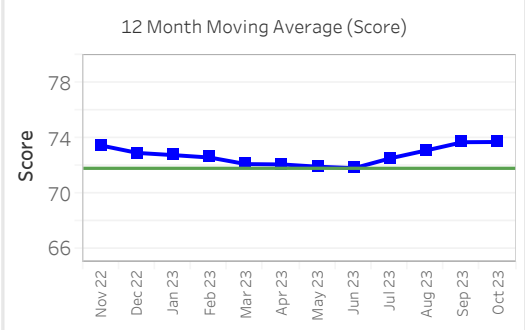
Quality Department | Note : updated as of November 21, 2023

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

October 2023 (unless other specified)

Month to Board Quality Committee : December 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : October 2023	82.4	83.6	78.5	76.4		
IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : October 2023	81.3	80.0	75.0	75.0		
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : October 2023	74.1	76.9	71.7	71.7		

Quality Department | Note : updated as of November 21, 2023

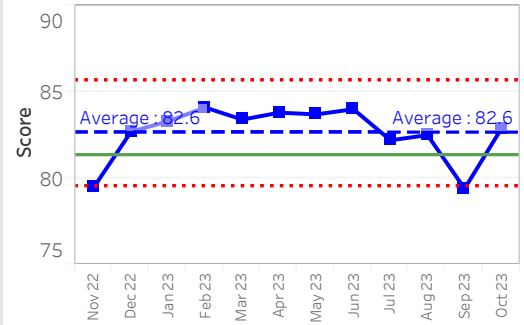
El Camino Health

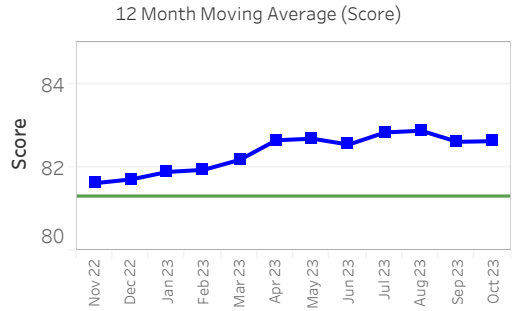
FY24 Enterprise Quality, Safety and Experience Dashboard

October 2023 (unless other specified)

Month to Board Quality Committee : December 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal ECHMN (El Camino Health Medical Network) Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : October 2023	82.9	81.8	82.7	81.3	BETTER	BETTER





Quality Department | Note : updated as of November 21, 2023

Measure	Definition Owner	Metric Definition	Data Source
*Organizational Goal HAC Index 2.0	H. Beeman, MD	For FY24, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (4) key inpatient safety events. The elements of the composite are weighted as noted: Clostridium difficile infections (C-Diff) 35%, Catheter Associated Urinary Tract Infection (CAUTI) 15%,Central Line Associated Blood Stream Infection (CLABSI) 15%, and non-ventilator hospital-acquired pneumonia (nvHAP) 35%,	See below
HAC Component Clostridium Difficile Infections (C-Diff)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
HAC Component Catheter Associated Urinary Tract Infection (CAUTI)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator**: Infection control Dept. **Denominator**: EPIC Report

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

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

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

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

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

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

Final Notes:
1.) SSER through September 2023
2.) Readmissions through September 2023
3.) PC-02 & PC-05 through August 2023
4.) Updated as of 2023-11-21

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: December 4, 2023
Subject: Quality Committee Follow-Up, HAC Index 2.0 Weighting

Purpose:

To provide follow-up to a request from the November 6, 2023, Quality Committee Meeting.

Summary:

Situation: The HAC Index 2.0 is a weighted index comprised of 4 individual quality measures, each one a hospital acquired condition. Non-ventilator pneumonia (nvHAP) is one of the 4 measures. We have changed the methodology of identifying nvHAP events to conform with current medical literature and peer-reviewed studies. We were previously over-reporting nvHAP by including non-infectious aspiration pneumonitis in the numerator. With the change in methodology, the baseline for FY23 changed from 112 nvHAP events to 20 nvHAP events.

Background: The committee requested that management review the current weighting of each component of the HAC Index 2.0 and consider changing the weighting of the individual measures.

Assessment: If a change is made, we recommend the committee consider weighing each measure equally. This will reduce the weight of nvHAP from 35% to 25%. Additionally, it will reduce the weight of C. Diff from 35% to 25%. The rationale supporting this change is that C. Diff rate is multiplied by 10,000 as opposed to all other measures being multiplied by 1,000. A reduction in C. Diff weighting will prevent one individual measure from having a disproportionate impact on the overall index. The two weighting scenarios are illustrated below.

HAC Index 2.0, Weighting Scenarios								
No change							Adjust to equal weighting for each measure	
FY23 Baseline	Numerator	Denominator	Multiplier per National Healthcare Safety Network (NHSN) guidelines *	FY23 Rate	FY24 Weighting	Weighted Rate	Change Weighting	Updated Baseline weighted rate
CAUTI	# events	# catheter days	x 1,000	0.68	15%	0.103	25%	0.171
CLABSI	# events	# central line days	x 1,000	0.62	15%	0.093	25%	0.154
C Diff	# events	# patient days	x 10,000	3.32	35%	1.162	25%	0.830
nvHAP	# events	# patient days	x 1,000*	0.27	35%	0.096	25%	0.068
					FY23 Baseline HAC Index	1.453	FY23 Baseline HAC Index	1.224
* nvHAP criteria not defined by NHSN					Target 3% Reduction	1.410	Target 3% Reduction	1.187

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: December 4, 2023
Subject: Voice of the Patient/Family Feedback

Purpose: To provide the Committee with written patient feedback that is received by the hospital from patients and/or families who received care at ECH regarding their caregivers.

Summary:

1. Situation: Multiple Daisy Award nominations are provided each month written by grateful patients or their families. There are between 40-75 each month. This month we are sharing three exceptional nominations.

2. Authority: To provide insight into the impact the care our staff give to our patients makes in the lives and experiences of our patients and families.

3. Background: Two of the nominations are written by grateful patients explaining the impact the nurse had on their care. Each nomination noted the sincere compassion the nurses have in delivering care. Many of the elements of the Press Ganey survey questions are identified as one reads the nominations. Treating patients courteously and respectfully, providing clear medication education, and explaining things in a way the patient can understand are all items on the survey. The third nomination is from a nursing school instructor commenting on the charge RN in L&D and how she treats the students with an open and welcoming approach.

4. Assessment: These notes illustrate that the patient experience training on WeCare standards is reaching our patients through our caregivers. In addition, the note from the nursing instructor is refreshing. Nursing instructors can have a great influence on their students after they leave the University regarding the “best places to work”. When our students and instructors are treated with open arms, our reputation of being a good place to work is solidified in the student's consciousness. With the workforce challenges in our industry, demonstrating a culture of excellence in professional standards as well as student/staff open communication strengthens our position for recruitment for new graduate nurses.

5. Other Reviews: None

6. Outcomes: El Camino leaders continue to provide training and feedback on WeCare standards. Daisy nominations are one way in which to verify if the training is making a difference.

7. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. What is the Daisy Award and why is it important to healthcare organizations?

2. What training do new nurses and students receive regarding WeCare standards?

Daisy #1

It is a great pleasure to have the opportunity to nominate Nurse XXXX for the DAISY Award. From our first meeting on the nursing unit, it was clear that she was someone wife and I could communicate with and trust. She was fully engaged, and her efficiency and positive energy contributed to my sense of wellbeing under stressful circumstances. The respect and consideration she showed my wife was an added comfort. Through time, her positive interactions with her peers and non-medical staff added to our comfort level. She showed patience and a genuine willingness to explain each procedure and medication before she administered it, and her explanations were thoughtful, to the point, and readily understandable, not only to me but to the gentleman I shared a room with. Her cogent description and explanation of a very complex medication and the equipment used to treat it was exceptional. Nurse XXXX consistently demonstrated a unique ability to anticipate questions and concerns almost before I or my wife voiced them. I never worried about getting a timely response to my call light, which eliminated any worries about whether my needs would be addressed. She went out of her way to provide practical advice on specific actions I could take to reduce my very apparent anxiety, which was most appreciated. With her encouragement and professional support, I was able to meet my daily goals, which in turn engendered a sense of satisfaction and boosted my confidence. I was fortunate to have been the beneficiary of her expertise and experience. In short, Nurse XXXX is the epitome of a “take charge nurse” whose contagious enthusiasm demonstrated a true generosity of spirit and a dedication to providing the highest quality of care.

Daisy #2

My nurse XXXX (RN), holds a special place in my heart. During a challenging time when I was hospitalized, her unwavering compassion and dedication made all the difference. Every night during her shifts, she went above and beyond her duties, listened to my fears and concerns, provided reassuring presence, and the personal/emotional well-being. She was exceptional in giving me moments of joy even in difficult circumstances. She shared stories, offered warm smiles, and her energy was infectious. As I prepare to go home, I feel immense gratitude for XXXX. Her exceptional care extended far beyond her professional duties. It was a testament to her kind and empathetic nature. She reminded me that even in the most challenging times, there are people like her who make a profound impact on our lives, leaving an indelible mark of compassion and humanity. XXXX will always be special to me for the comfort, care, and hope she brought into my life when I needed it most.

Thank you!

Daisy #3

XXXX is such a welcoming, caring nurse. When the students arrive on the unit, she immediately welcomes them. Even when the board is completely full, she goes above and beyond to make sure they have an amazing clinical experience. Students from SJSU can’t say enough good things about their experiences on the L&D unit at ECH. Most days, we are here XXXX is in charge and always makes amazing things happen. Thank you XXXX for really showing what a Magnet hospital does. You are amazing!

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: December 4, 2023
Subject: El Camino Health, Update on Health Equity

Purpose:

During the June 5, 2023, Quality, Patient Care and Patient Experience Committee meeting, a focused review on Health Equity initial priorities and initiatives for El Camino Health was discussed. The initial Health Equity Plan was also shared with the El Camino Health Board of Directors in August 2023. Both governing bodies endorsed the direction of the work. An update on the status of our Health Equity initiatives will be reviewed during our December 4, 2023, meeting.

Summary:

El Camino Health, Health Equity Initial priorities as discussed in the June 2023 Quality Committee Meeting are:

1. Identify who, when & how our team will collect Race Ethnicity Language-Disability (REaL-D), Sexual Orientation and Gender Identity (SOGI), Social Drivers of Health (SDOH) data. The gold standard for collecting accurate information in these domains is that it is patient self-reported.
2. Optimize technology and tools for data collection an analysis.
3. Four initial initiatives identified.
    1. Quality Council Reporting and Analysis with an equity lens
    2. Communicate with patients in their preferred language
    3. Is our management of Sepsis patients free from bias
    4. Do we recognize and support homeless patients per our policies

Progress on Priorities:

1. Patient data collection and technology optimization.
    a. The electronic medical record, EPIC, has a module to facilitate the collection, capture, and analysis of patient reported information on REAL, SOGI and SDOH. This module has just been implemented and our team is focused, in partnership with Information Technology, Care Coordination, Social Work and the Health Equity teams to optimize the build and tools in EPIC. For example, we currently have greater than 30 race/ethnicity combinations and options. This challenges trending and analytics as there are several race/ethnicity groups with very small numbers of patients (<10). We will continue to collect this information to a granular level, and, for the purposes of analytics and improvement efforts we will aggregate race and ethnicity subgroups to map up to larger groupings. We will deploy a race and ethnicity mapping process to resemble the proposed new race and ethnicity changes to be adopted by the Office of Management and Budget (OMB) for future US Census Surveys. (The White House, 2023)
    b. We have identified the need to have a new role/individual with a social work and health equity background join the Care Coordination team to manage, train, and

validate our processes for collecting self-reported patient information on REaL, SOGI and SDOH data. We are in the process of moving the process forward to post a job description and recruit an individual for this role.

2. Four Initiatives
    a. Quality Council Reporting
        i. We have refined the template departments utilize to report their process improvement initiatives and outcomes. Additionally, the Quality and Health Equity teams are providing support, analytics and thought partnering to enable each department to report on at least one measure through an equity lens. Attached to this memo is an example from the November 2023 Quality Council Meeting from Maternal Child Health Service Line. By segregating outcomes by race (cesarean section rates, exclusive breast feeding), the service line has introduced race and culture sensitive support to better meet the needs of unique patient populations.
        ii. In the upcoming Quality Council meeting (you will see these minutes in the next Board Quality Committee meeting) the Spine Service Line is studying how a patient's health insurance impacts readmission rates. They hypothesize that patients with 'better' health insurance have resources available to them post-discharge such as home physical therapy, a short-term rehab stay after discharge. The Respiratory Care Department is exploring the pneumonia readmission rates by age with the hypothesis that age impacts readmission. Interestingly in their initial analysis, patients from age 65 to 74 have a 21% readmission rate, much higher than older patients who are 75 or older.
    b. Communicating with patients in their preferred language. This initiative is driving improvement with two parallel paths. First, increasing the availability of language translation iPad in the pilot unit 3C. Second, optimizing the training and tools provided to our registration team to determine more accurately which of our patients would benefit from translation services. We have learned from the current President of the Commonwealth Fund, previously the VP of Health Equity at Harvard's Mass General Hospital, on best practices to address this challenge from the Institute for Healthcare Improvement Leadership Alliance meeting I attended in Boston in October 2023.
    c. Sepsis bundle compliance by race. This topic and our initial findings have been described in our November 6, 2023, Quality Committee meeting and STEEEP report.
    d. Homeless patient support at discharge. Our efforts and progress in this area were also discussed during our November 6, 2023, Quality Committee meeting and STEEEP report review.

Bibliography

The White House. (2023, January 26). *U.S. Office of Management and Budget Interagency Technical Working Group on Race and Ethnicity Standards*. Retrieved from Initial Proposals for Revising the Federal Race and Ethnicity Standards: https://spd15revision.gov/

Attachment: Maternal Child Health Performance Improvement Summary (November 2023 Quality Council)

El Camino Health

Maternal Child Health

Performance Improvement (PI) Summary

Department/Service:
MCH Service Line, OB

AIM:
NTSV CS rate ≤ 23.9% in FY24.

Performance
We have trended up over the last year.

Measures:
- Associated: operative vaginal delivery rates, induction rates (correlated)
- Process: ACOG guidelines, patient positioning
- Balancing: Unexpected Newborn Complications

Rationale
Background: Why choose this metric for focus/improvement?
- Cesarean births contribute to an increase in maternal hemorrhage risk, uterine rupture, abnormal placentation, and cardiac events.
  - Neonates are also at risk, including higher rates of serious respiratory complications and admission to the NICU.

Report Period
FY23 – 24

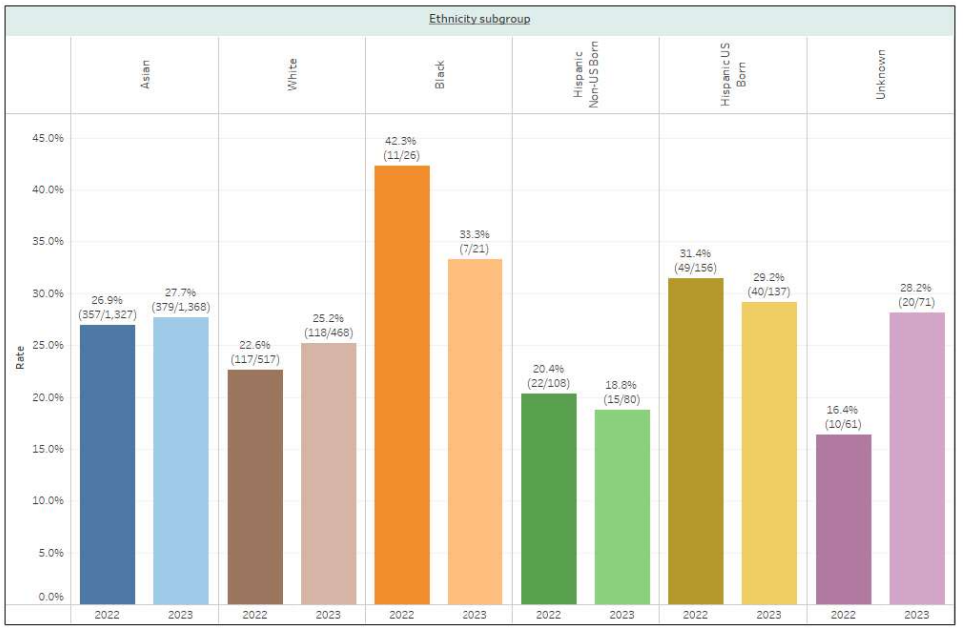
Most recent date reported
Jul 2023

Rationale Key
This indicator has been chosen because (check one or more):
- **It affects a high volume of patients**
- It is a high-risk procedure
- **Is a problem-prone process/area**
- **It is a required review for hospital quality assurance**

Performance Analysis (barriers, issues, patterns)
- Correlated w higher induction rate
- ACOG standards variably followed and not previously checked or followed up
- Nurse standards not identified or followed
- Lack of clinician education: OB and RN
- Lack doula integration program
- Lack of patient education

Action Taken/Follow up Planned:
- Quarterly unblinded data to OBs, also distributed data to RNs
- Support for outlier OBs provided
- Implemented CMQCC NTSV checklist
- Provided OB and RN education
- Developed class for S. Asian pts (largest population with high rate—see below)
- Developing NTSV case review process (bi-weekly)
  Evaluating doula integration programs, developing Doula list for pts

Status of your project at the time of report to committee
(select one of the four following choices)
- Goal Achieved
- Making steady progress
- 50% toward goal
- **Goal not achieved; required new action plan**

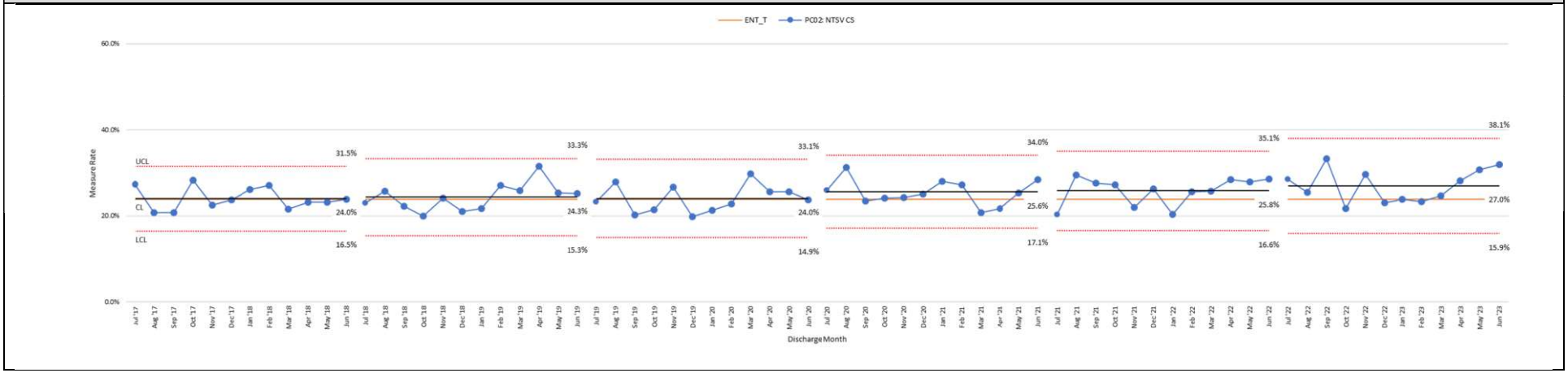


Maternal Child Health
Performance Improvement (PI) Summary

Control Chart:

QUALITY MEASURES	FY Performance		Baseline FY23	FY24 Target	
Source: CMQCC & CPQCC	Latest Month	FYTD			Metric Definition
PC02: NTSV CS	27.2% (49/180)	27.2% (49/180)	27.0%	23.9%	This metric shows the Cesarean births among Nulliparous, Term, Singleton, Vertex (NTSV) deliveries. **Numerator**: All deliveries that are Nulliparous, Term, Singleton, Vertex (NTSV) delivered by Cesarean excluding: • Multiples • Breech • Preterm • With Placenta Previa • With History of Prior Live Birth **Denominator**: All deliveries that are Nulliparous, Term, Singleton, Vertex (NTSV) excluding: • Multiples • Breech • Preterm • With Placenta Previa • With History of Prior Live Birth
Latest Month: Jul 2023					

Trend



El Camino Health

Maternal Child Health

Performance Improvement (PI) Summary

Department/Service
MCH Service Line

AIM
- Increase the Enterprise Exclusive Breastfeeding Rate (PC05) to 65.1% (CMQCC 50th percentile) by June 30, 2024.
  - MV PC-05 rate ≥ 65.1% (CMQCC mean)
  - LG PC-05 rate ≥ 70.5% (CMQCC top quartile)

Measure:
- Associated: NA
- Process: Formula use, banked milk use
- Balancing: NA

Rationale: *(Background)*
- Exclusive breastfeeding rates at hospital discharge are a predictor of breastfeeding duration at 6 weeks, 3 months, 6 months and at 1 year of life. The longer an infant receives breastmilk, the greater the health benefits to both the baby and the mother.
- 2023 Exclusive Breastfeeding rates:
  - Enterprise: 59.6%
  - Mountain View: 58%
  - Los Gatos: 68.1

Report Period
2023

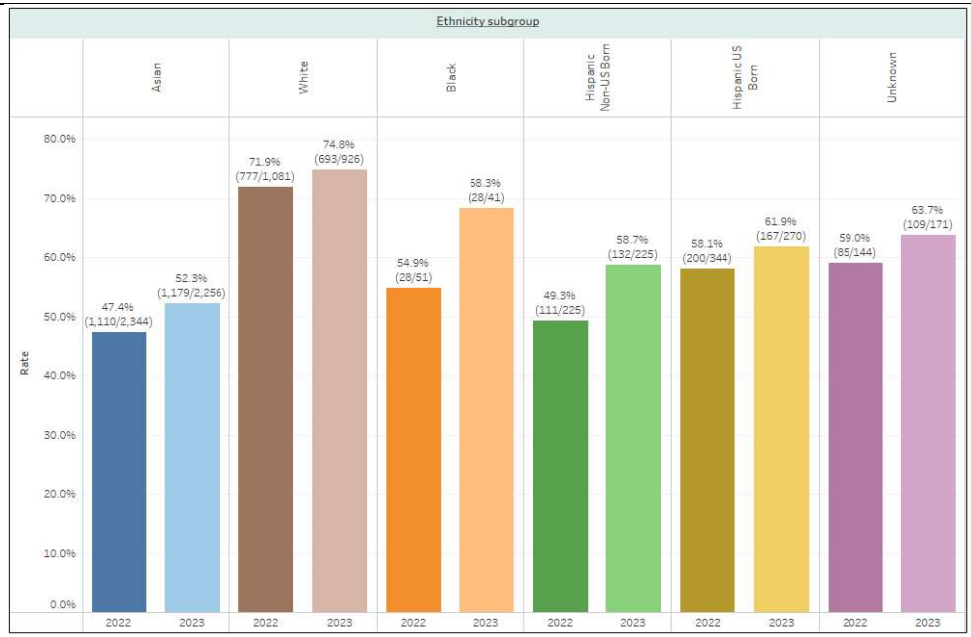
Most recent date reported
July 2023

Rationale Key :
This indicator has been chosen because (check one or more):
- **It affects a high volume of patients**
- It is a high-risk procedure
- Is a problem-prone process/area
- **It is a required review for hospital quality assurance**

Analysis/ Discussion:
- Los Gatos has consistently had higher exclusive breastfeeding rates due to lower risk patients and a higher percentage of multiparas vs primiparas.
- Improvement has been slow over past several years
- We are seeing a pattern of improvement since the addition of banked donor milk availability to all term infants as of August 2023.

Action Taken/ Follow Up Planned:
- Continue monitoring monthly breastfeeding rates on both campuses, including identifying outliers of nursing staff who offer more first formula than colleagues do.
- Continue to refine the banked donor milk for term infants rollout to improve nursing and MD workflow, increasing use of donor milk instead of formula if supplementation needed or requested.
- Complete the 2 corrective actions in LG to complete their Baby Friendly re-designation process.
- Continue with the interdisciplinary Baby Friendly Designation process in MV including training of staff and providers, updating the infant feeding policy, and expanding prenatal breastfeeding education.

Status of your project at the time of report to committee
(select one of the four following choices)
- Goal Achieved
- **Making steady progress**
- 50% toward goal
- Goal not achieved; required new action plan

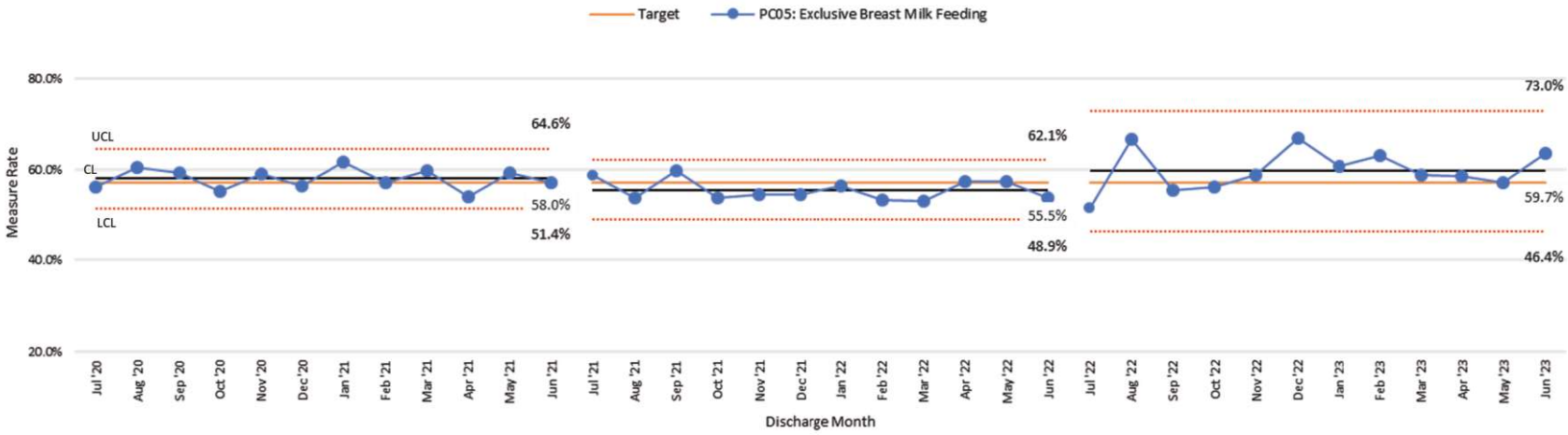


Maternal Child Health
Performance Improvement (PI) Summary

Control Chart:

QUALITY MEASURES	FY Performance		Baseline FY23	FY24 Target	
Source: CMQCC & CPQCC	Latest Month	FYTD			Metric Definition
PC05: Exclusive Breast Milk Feeding	62.9% (217/345)	62.9% (217/345)	59.7%	65.1%	This metric shows the exclusive breast milk feeding during the entire hospitalization among non-NICU Term infants. **Numerator**: Singleton inborn newborns that were exclusively breast milk fed during the entire birth hospital stay excluding those with: • Under 37 weeks gestational age • Admitted to NICU • Transferred • Expired prior to discharge • With code for Galactosemia • With code for Parenteral Nutrition **Denominator**: Singleton inborn newborns excluding those with: • Under 37 weeks gestational age • Admitted to NICU • Transferred • Expired prior to discharge • With code for Galactosemia • With code for Parenteral Nutrition
Latest Month: Jul 2023					

Trend



El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Lyn Garrett, Senior Director Quality
Date: December 5, 2023
Subject: Patient Safety Indicator (PSI) Scores FY 2023

Purpose: To provide an update on the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators.

Summary:

1. Situation: The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events for all patients including following surgeries, procedures, and childbirth. The PSIs were developed by AHRQ after a comprehensive literature review, analysis of ICD-10-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.

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

3. Background: The PSIs can be used to help hospitals identify potential adverse events that might need further study; provide the opportunity to assess the incidence of adverse events and in-hospital complications using administrative data found in the typical discharge record; and include indicators for complications occurring in hospital that may represent patient safety events. These indicators also have area level analogs designed to detect patient safety events on a regional level. Additionally, PSIs are embedded in public reported scores and methodologies, like Hospital Compare, Leapfrog, & US News and World report.

4. Assessment: Each of the identified PSIs are first reviewed and validated by ECH Clinical Documentation Integrity and Coding professionals. If questions arise then clarifications from physicians are obtained. After cases are confirmed, identified cases are sent through the Medical Staff's Peer review process for trending by physician. The collaboration between physicians, clinical documentation specialists and coding team is imperative for an accurate reflection of these patient safety events.

5. Performance:
- **A.** PSI-04 Death in Surgical Pts with treatable complications – 15 in FY 2023, an increase from 12 cases in FY 2022
- **B.** PSI-03 Pressure Ulcer decreased from 4 in FY 2022 to 2 in FY 2023
- **C.** PSI-05 Retained Surgical Item or Unretrieved Device Fragment – 1 reported in FY 2023
- **D.** PSI-08 In Hospital Fall with Hip Fracture – 0 to report from FY 2023; 2 were reported in FY 2022
- **E.** PSI-17 Birth Trauma Injury to Neonate – 14 occurrences FY 2023; 16 were reported in FY 2022

List of Attachments:

1. Patient Safety Indicator (PSI) Scores FY23 & FY24 YTD

Patient Safety Indicator Report (AHRQ) All Patients
FY 2022 - FY 2023

Patient Safety Indicator	FY 2022			FY 2023			Premier
	Numerator	Denominator	Rate/1000	Numerator	Denominator	Rate/1000	Mean
PSI-02 Death in Low Mortality DRGs	0	1372	0.00	0	1455	0.00	0.75
PSI-03 Pressure Ulcer	4	8728	0.46	2	9737	0.21	0.64
PSI-04 Death in Surgical Pts w Treatable Complications	12	130	92.31	15	101	148.51	134.62
PSI-05 Retained Surgical Item or Unretrieved Device Fragment	0	26090	0.00	1	Not Provided	Not Provided	0.15
PSI-06 Iatrogenic Pneumothorax	1	13634	0.07	2	14540	0.14	0.12
PSI-07 Central Venous Catheter-Related Blood Stream Infection	0	13540	0.00	1	14281	0.07	0.07
PSI-08 In Hospital Fall with Hip Fracture	2	14359	0.14	0	15225	0.00	0.07
PSI-09 Postoperative Hemorrhage or Hematoma	7	3668	1.91	7	3496	2.00	1.63
PSI-10 Postoperative Acute Kidney Injury Requiring Dialysis	1	1782	0.56	1	1735	0.58	0.8
PSI-11 Postop Respiratory Failure	2	1720	1.16	5	1659	3.01	8.04
PSI-12 Perioperative PE or DVT	9	3898	2.31	12	3757	3.19	3.64
PSI-13 Postop Sepsis	1	1764	0.57	7	1683	4.16	5.24
PSI-14 Postop Wound Dehiscence	1	1480	0.68	2	1586	1.26	2.1
PSI-15 Abdominopelvic Accidental Puncture or Laceration	4	3322	1.20	3	3397	0.88	1.03
PSI-17 Birth Trauma Injury to Neonate	16	5065	3.16	14	4735	2.96	3.59
PSI-18 OB Trauma Vaginal Delivery with Instrument	48	281	170.82	48	247	194.33	95.13
PSI-19 OB Trauma Vaginal Delivery without Instrument	85	3170	26.82	97	3002	32.31	16.75
Total Non-OB PSIs	**44**			**58**			
Total PSIs	**193**			**217**