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

Monday, February 5, 2024 – 5:30 pm
El Camino Health | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

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


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.

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>PRESENTED BY</th>
<th>ACTION</th>
<th>ESTIMATED TIMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CALL TO ORDER/ROLL CALL</td>
<td>Carol Somersille, MD Quality Committee Chair</td>
<td></td>
<td>5:30 – 5:32 pm</td>
</tr>
<tr>
<td>2. CONSIDER APPROVAL FOR AB 2449 REQUESTS</td>
<td>Carol Somersille, MD Quality Committee Chair</td>
<td>Possible Motion</td>
<td>5:32 – 5:33</td>
</tr>
<tr>
<td>3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</td>
<td>Carol Somersille, MD Quality Committee Chair</td>
<td>Information</td>
<td>5:33 – 5:34</td>
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<tr>
<td>4. PUBLIC COMMUNICATION</td>
<td>Carol Somersille, MD Quality Committee Chair</td>
<td>Information</td>
<td>5:34 – 5:37</td>
</tr>
<tr>
<td>a. Oral Comments</td>
<td></td>
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<tr>
<td>b. Written Public Comments</td>
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<tr>
<td>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.</td>
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<tr>
<td>5. CONSENT CALENDAR ITEMS</td>
<td>Carol Somersille, MD Quality Committee Chair</td>
<td>Motion Required</td>
<td>5:37 – 5:47</td>
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<tr>
<td>Any Committee Member or member of the public may pull an item for discussion before a motion is made.</td>
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<tr>
<td>a. Approve Minutes of the Open Session of the Quality Committee Meeting (12/04/2023)</td>
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<tr>
<td>b. Approve Minutes of the Closed Session of the Quality Committee Meeting (12/04/2023)</td>
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<tr>
<td>c. Receive FY24 Pacing Plan</td>
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<tr>
<td>d. Receive Committee Follow-up Item: 6/1/2020 Report on Obstetrical Lacerations</td>
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<tr>
<td>e. Receive Committee Follow-Up Item: Hand Hygiene Project Overview</td>
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<tr>
<td>6. VERBAL CHAIR’S REPORT AND IHI HIGHLIGHTS</td>
<td>Carol Somersille, MD Quality Committee Chair</td>
<td>Information</td>
<td>5:47 – 5:52</td>
</tr>
</tbody>
</table>

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

Next Meeting: March 4, 2024, May 6, 2024, June 3, 2024
Minutes of the Open Session of the Quality, Patient Care and Patient Experience Committee of the El Camino Health Board of Directors
Monday, December 4, 2023
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

<table>
<thead>
<tr>
<th>Members Present</th>
<th>Members Absent</th>
<th>Others Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carol Somersille, MD</td>
<td>Krutica Sharma, MD</td>
<td>Holly Beeman, MD, MBA, CQO</td>
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<tr>
<td>Melora Simon (at 5:33 p.m.)</td>
<td></td>
<td>Dan Woods, CEO</td>
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<tr>
<td>John Zoglin (at 5:34 p.m.)</td>
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<td>Mark Adams, MD, CMO</td>
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<tr>
<td>Pancho Chang</td>
<td></td>
<td>Theresa Fuentes, CLO</td>
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<tr>
<td>Jack Po, MD (at 5:35 p.m.)</td>
<td></td>
<td>Christine Cunningham, Chief</td>
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<tr>
<td>Philip Ho, MD (at 5:37 p.m.)</td>
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<td>Experience and Performance</td>
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<tr>
<td>Prithvi Legha, MD</td>
<td></td>
<td>Improvement Officer</td>
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<td></td>
<td></td>
<td>Cheryl Reinking, DPN, RN, CNO</td>
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<td></td>
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<td>Shreyas Mallur, MD, ACMO</td>
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<td></td>
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<td>Lyn Garrett, Senior Director, Quality</td>
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<td>Tracy Fowler, Director, Governance</td>
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<td>Services</td>
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<td></td>
<td></td>
<td>Nicole Hartley, Executive Assistant II</td>
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<td></td>
<td></td>
<td>Gabriel Fernandez, Coordinator,</td>
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<td></td>
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<td>Governance Services</td>
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</tbody>
</table>

**via teleconference**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Comments/Discussion</th>
<th>Approvals/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CALL TO ORDER/ ROLL CALL</td>
<td>The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Health (the “Committee”) was called to order at 5:32 p.m. by Chair Carol Somersille. A verbal roll call was taken. Committee members Jack Po, Krutica Sharma, Phillip Ho, Melora Simon, and John Zoglin were absent from the roll call. All other members were present at the roll call and participated in person. A quorum was not present until Melora Simon arrived at 5:33 p.m. John Zoglin arrived at 5:34 p.m. Jack Po arrived at 5:35 p.m. Phillip Ho arrived at 5:37 p.m. No votes were taken on any items until after Committee Member Simon’s arrival.</td>
<td>Call to order at 5:32 p.m.</td>
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<tr>
<td>2. CONSIDER APPROVAL FOR AB 2449 REQUESTS</td>
<td>No members of the Committee participated remotely, and no AB 2449 requests were submitted.</td>
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<tr>
<td>3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</td>
<td>Chair Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.</td>
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<td>4. PUBLIC COMMUNICATION</td>
<td>There were no comments from the public.</td>
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5. **CONSENT CALENDAR**  
Chair Somersille asked if any Committee member would like to pull an item from the consent calendar.

**Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (11/06/2023), (b) Minutes of the Closed Session of the Quality Committee Meeting (11/06/2023)

Received: (c) Progress against FY24 Committee Goals

**Movant**: Zoglin  
**Second**: Po  
**Ayes**: Somersille, Chang, Simon, Zoglin, Po, Legha, Ho  
**Noes**: None  
**Abstain**: None  
**Absent**: Sharma  
**Recused**: None

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6. **VERBAL CHAIR’S REPORT**  
Chair Somersille provided a verbal Chair’s report to the committee. In the report, Chair Somersille shared the knowledge she gained at the Health Quality Improvement Conference, noting that a key takeaway was how advanced ECH is compared to presenters at the conference on Quality and Health Equity performance and initiatives.

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7. **RECEIVE FY24 ENTERPRISE QUALITY DASHBOARD**  
Dr. Holly Beeman, CQO, presented an update on the FY24 Enterprise Quality Dashboard. Dr. Beeman provided an in-depth analysis of performance, process improvement initiatives, and HAC Index 2.0 performance measures. Discussion about hand hygiene results took place and the committee recommends the current hand hygiene compliance measures are not included in the dashboard going forward. Dr. Beeman will provide more detail on the Hand Hygiene improvement initiatives as a follow-up item for the next committee meeting.

**Motion**: To receive the FY24 Enterprise Quality Dashboard

**Movant**: Po  
**Second**: Chang  
**Ayes**: Somersille, Chang, Simon, Zoglin, Po, Legha, Ho  
**Noes**: None  
**Abstain**: None  
**Absent**: Sharma  
**Recused**: None

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8. **RECEIVE FOLLOW-UP ITEM - HAC 2.0 WEIGHTING**  
Dr. Holly Beeman, CQO, provided information on the request from the committee to review the current weighting of each component of the HAC Index 2.0, with consideration to changing the weighting of the individual measures or potentially keeping them at their current weighting. After discussion amongst the committee and staff, a motion was made to change the weighting of the measures.

**Motion**: To change the weighting of HAC Index 2.0 measures to 25%, for each measure

**Actions**: HAC 2.0 Index measures to be adjusted to be weighed at 25%, for each measure.

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

**Motion:** To receive FY2023 PSI report  
**Movant:** Simon  
**Second:** Po  
**Ayes:** Somersille, Chang, Simon, Zoglin, Po, Legha, Ho  
**Noes:** None  
**Abstain:** None  
**Absent:** Sharma  
**Recused:** None

| 12. RECESS TO CLOSED SESSION | Motion: To recess to closed session  
**Movant:**  
**Second:**  
**Ayes:** Somersille, Chang, Simon, Zoglin, Po, Legha, Ho  
**Noes:** None  
**Abstain:** None  
**Absent:** Sharma  
**Recused:** None  
**Recessed to closed session at 6:43 p.m.** |

| 13. AGENDA ITEM 18: CLOSED SESSION REPORT OUT | During the closed session, the Quality Committee approved the recommendation of the Credentialing and Privileges Report for approval by the El Camino Hospital Board of Directors, by a unanimous vote of all members present.  
**Reconvened Open Session at 7:13 p.m.** |

| 14. AGENDA ITEM 19: COMMITTEE ANNOUNCEMENTS | Chair Somersille recounted and confirmed action items for staff and the committee. No further announcements were made by the committee. |

| 15. AGENDA ITEM 20: ADJOURNMENT | **Motion:** To adjourn at 7:17 p.m.  
**Movant:** Po  
**Second:** Simon  
**Ayes:** Somersille, Chang, Simon, Zoglin, Po, Legha, Ho  
**Noes:** None  
**Abstain:** None  
**Absent:** Sharma  
**Recused:** None  
**Adjourned at 7:17 p.m.** |

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

___________________________________________  
Gabriel Fernandez, Governance Services Coordinator

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

<table>
<thead>
<tr>
<th>Standing Agenda Items</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent Calendar*</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient Experience Story</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Serious Safety/Red Alert Event (as needed)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Credentialing and Privileges Report</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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### 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 STEEP Dashboard measures for FY25                 | ✓  | ✓  | ✓  | ✓  |

### Committee/organizational Goals/Calendar

| Propose Committee Goals                                    | ✓  | ✓  | ✓  | ✓  |
| Approve Committee Goals                                    | ✓  | ✓  | ✓  | ✓  |
| Propose FY Committee Meeting dates                        | ✓  | ✓  | ✓  | ✓  |
| Approve FY Committee Meeting dates                        | ✓  | ✓  | ✓  | ✓  |
| Propose Organizational Goals                              | ✓  | ✓  | ✓  | ✓  |
| Approve Organizational Goals                              | ✓  | ✓  | ✓  | ✓  |
| Propose Pacing Plan                                        | ✓  | ✓  | ✓  | ✓  |
| Approve Pacing Plan                                        | ✓  | ✓  | ✓  | ✓  |
| Review Charter                                            | ✓  | ✓  | ✓  | ✓  |

1: Includes Approval of Minutes (Open & Closed), Current FY Enterprise Quality Dashboard, Med Staff Quality Council Minutes (Closed Session), Progress Against FY Committee goals (Quarterly), Current FY Pacing Plan (Quarterly), QC Follow Up Items, Patient Safety Report (Sept), CDI Dashboard (Semi-Annual), Core Measures (Semi-Annual), Leapfrog (June)
El Camino Health Board of Directors
Quality, Patient Care and Patient Experience Committee Memo

To: Quality, Patient Care, and Patient Experience Committee
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: February 5, 2024
Subject: December 5, 2023, Quality Committee Follow-up Item, Obstetrical Lacerations

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

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

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

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

Summary:

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

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

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

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

5. **Other Reviews:** None.

6. **Outcomes:** None.

List of Attachments:

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

Suggested Committee Discussion Questions: None
## Patient Safety Indicator Report (AHRQ)
### FY20 Q3 compared to FYTD Q1-Q3

<table>
<thead>
<tr>
<th>Patient Safety Indicator</th>
<th>Numerator (FY20, Q3)</th>
<th>Denominator (FY20, Q3)</th>
<th>Rate/1000 (FY20 Q3)</th>
<th>Premier Mean*</th>
<th>Numerator (FY20, Q1-3)</th>
<th>Denominator (FY20, Q1-3)</th>
<th>Rate/1000 (FY20 Q1-3)</th>
<th>Premier Mean*</th>
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</thead>
<tbody>
<tr>
<td>PSI-02 Death in Low Mortality DRGs</td>
<td>0</td>
<td>158</td>
<td>0.00</td>
<td>0.54</td>
<td>0</td>
<td>554</td>
<td>0.00</td>
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<tr>
<td>PSI-03 Pressure Ulcer</td>
<td>0</td>
<td>1,979</td>
<td>0.00</td>
<td>0.46</td>
<td>3</td>
<td>5,607</td>
<td>0.54</td>
<td>0.46</td>
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<tr>
<td>PSI-04 Death in Surgical Pts w Treatable Complications</td>
<td>3</td>
<td>19</td>
<td>157.89</td>
<td>120.99</td>
<td>10</td>
<td>76</td>
<td>131.58</td>
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<td>PSI-06 Iatrogenic Pneumothorax</td>
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<td>3,102</td>
<td>0.00</td>
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<td>2</td>
<td>9,405</td>
<td>0.21</td>
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<tr>
<td>PSI-07 Central Venous Catheter-Related Blood Stream Infection</td>
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<td>2,626</td>
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<td>0</td>
<td>8,105</td>
<td>0.00</td>
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<tr>
<td>PSI-08 In Hospital Fall with Hip Fracture</td>
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<td>2,659</td>
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Source: Quality Advisor 5/20/20
PSI 18 & 19: OB Perineal Laceration Report

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Above National Average, Below Santa Clara County Average

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### California Performance: CMQCC
- 3rd and 4th degree laceration, all vaginal deliveries, Apr 2019-Mar 2020, peer comparison

- El Camino-Mountain View: 4.3%
- Santa Clara County: 5.7%
- El Camino Systemwide: 4.1%
- Mid-Coastal RPCC: 3.6%
- PRIME Hospitals: 2.9%
- NICU Level III/IV - CA MDC: 2.6%
- Delivery Volume: 3000-3999 - All MDC: 2.8%
- CA MDC: 2.6%
Performance Over Time: 2017 Q2 - 2020 Q1

3rd and 4th Degree Laceration, All

• 3rd and 4th Degree Laceration with Instrument
3rd and 4th Degree Lacerations Analysis FY20 thru April

- **Total 3rd and 4th degree lacerations**: 110
  - 3rd degree: 90% (99)
  - 4th degree: 10% (11)
- **Delivery types**
  - Inductions: 34.5% (38)
  - **Spontaneous delivery**: 72% (79)
    - Vaginal breech: 1
- **Instruments**
  - Vac-assist delivery: 33% (36)
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- **Episiotomy**: 15% (17)
  - Medial: 11 (10 = 3rd degree)
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ACOG Practice Bulletin 2016: Prevention and Management of Obstetric Lacerations

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

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

---

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

- 64% Asian OB population at ECH MV
- 76% of 3rd and 4th degree lacerations at ECH are in the Asian population
- Perineal Body Length:
  - Asian population has shortest perineal body length, therefore the greatest risk for 3rd/4th degree laceration
    - Yeaton-Massey et al., 2015; Deering et al., 2004
ECH MV Asian Population is 4x the California Average
CA Asian/Pacific Islander risk of laceration is 2X higher than the average

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

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

- CA overall rate: 2.6%
- CA Asian/Pacific Islander rate: 5.5%
- ECH LG Asian/Pacific Islander rate: 4.3% (6/139)
Risk Factor: Operative Vaginal Delivery

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

- Episiotomy trends to trend more closely with laceration rates.
- ECH episiotomy rate is 1% higher than CA average
- Per our analysis, most are medial (higher risk)
- Opportunity to improve
Initiatives to Decrease OB Trauma

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

**Target: Improve MV 3rd and 4th degree laceration with instrument by 15% from 22.2% to 18.9% on MV campus by July 1, 2020; FYTD = 21.6%**
El Camino Health Board of Directors  
Quality, Patient Care and Patient Experience Committee Memo

To: Quality, Patient Care, and Patient Experience Committee  
From: Holly Beeman, MD, MBA, Chief Quality Officer  
Date: February 5, 2024  
Subject: December 5, 2023, Quality Committee Follow-up Item, Obstetrical Lacerations

**Purpose:**

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

**Background:**

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

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

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

Summary:

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

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

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

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

5. Other Reviews: None.

6. Outcomes: None.

List of Attachments:

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

Suggested Committee Discussion Questions: None
Patient Safety Indicator Report (AHRQ)
FY20 Q3 compared to FYTD Q1-Q3

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<th>Patient Safety Indicator</th>
<th>Numerator (FY20, Q3)</th>
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    - **Consider medial-lateral episiotomy**

2016 ACOG Committee Opinion #647:
Limitations of Perineal Lacerations as an Obstetric Quality Measure

*Not recommended as quality measure due to variable definitions, mostly non-modifiable risk factors, and reducing rate likely to result in increased C-sections*
Risk Factor: Asian Ethnicity

- 64% Asian OB population at ECH MV
- 76% of 3rd and 4th degree lacerations at ECH are in the Asian population
- Perineal Body Length:
  - Asian population has shortest perineal body length, therefore the greatest risk for 3rd/4th degree laceration
    - Yeaton-Massey et al., 2015; Deering et al., 2004
ECH MV Asian Population is 4x the California Average
CA Asian/Pacific Islander risk of laceration is 2X higher than the average

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

ECH performs at average for Asian/Pacific Islander Population
Los Gatos Campus 3\textsuperscript{rd} and 4\textsuperscript{th} degree laceration rate is average, with Asian/Pacific Islander population performing worse, similar to CA

- CA overall rate: 2.6%
- CA Asian/Pacific Islander rate: 5.5%
- ECH LG Asian/Pacific Islander rate: 4.3% (6/139)
**Risk Factor: Operative Vaginal Delivery**

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

- Episiotomy tends to trend more closely with laceration rates.
- ECH episiotomy rate is 1% higher than CA average.
- Per our analysis, most are medial (higher risk).
- Opportunity to improve.
Initiatives to Decrease OB Trauma

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

- **Target:** Improve MV 3rd and 4th degree laceration with instrument by 15% from 22.2% to 18.9% on MV campus by July 1, 2020; FYTD = 21.6%
El Camino Health Board of Directors
Quality, Patient Care and Patient Experience Committee Memo

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

Purpose:

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

Recommendation:

Informational only.

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

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

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

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

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

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

4. Outcomes:

- A multidisciplinary process improvement team has been developed to conduct a thorough review and identify opportunities for improvement.
Hand Hygiene Process Improvement
February 5, 2024

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

List of Attachments:
Attachment 1: Hand Hygiene A3 document

Works Cited
Title: Hand Hygiene Program  
Sponsor(s): Holly Beeman, Lyn Garrett  
Team: Ann Aquino, Dee Shih, Julie Belisle, Jerry Kelly, Padmaja Vemula MD, Thai Vo MD, Linda Huynh MD  
Process Owners: Catherine Nalesnik, Alyssa Santos, Stephelie Dumalag, Daniel Shin MD  
Rev: 6 Date: 1/10/24

Background: What problem are we talking about and why?

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

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

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

Current Conditions: Where do things stand now?

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

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

Survey learnings: Staff didn’t recognize “germs already present on the patient” as the most frequent source of germs responsible for HAIs.

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

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

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

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

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

Top Contributors | Cause
--- | ---
Audit process: Inconsistent auditing process | • Variability in training
• Training is done by different people
• There is no agreed upon process or materials for training

Experiments: What do you propose and why?

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

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

ECH Quality Committee Meeting Materials Packet - PUBLIC - February 5, 2024 Page 44 of 127
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Study, Reflect, Plan Next Steps: How will you assure ongoing PDSA?

ECH Quality Committee Meeting Materials Packet - PUBLIC - February 5, 2024 Page 47 of 127
To: Quality Committee of the Board of Directors, El Camino Health  
From: Cheryl Reinking, DNP, RN, NEA-BC, DiplACLM  
Date: February 5, 2024  
Subject: Patient Voice/Press Ganey Comment

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

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

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

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

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

5. **List of Attachments:** See patient comments.

**Suggested Committee Discussion Questions:**

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

2. How else do we receive feedback from patients who deliver here during construction and make changes based on their feedback?
Patient Voice/Press Ganey Comment
February 5, 2024

**Patient Comment: Press Ganey 1/19/2024**

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

**Patient Comment: Press Ganey 11/7/23**

“New wing for L&D was lovely. The bed, both couch/bed were better than expected. Some directions on how to use the lights could have been helpful”
El Camino Health Board of Directors
Quality, Patient Care and Patient Experience Committee Memo

To: Quality, Patient Care and Patient Experience Committee
From: Holly Beeman, MD, MBA, and Chief Quality Officer
Date: February 5, 2024
Subject: Enterprise Quality, Safety and Experience and STEEEP Dashboards through December 2023

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

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

A. Safe Care
Hospital Acquired Condition Index 2.0

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

<table>
<thead>
<tr>
<th>FY 24 HAC 2.0 weighting and targets</th>
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<tbody>
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<tr>
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</tr>
<tr>
<td>CAUTI</td>
</tr>
<tr>
<td>C. Diff</td>
</tr>
<tr>
<td>nvHAP</td>
</tr>
<tr>
<td>SUM</td>
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</table>

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

1.1. C. Difficile Infection: The C. Diff rate per patient days x 10,000 (1.112) for the second quarter and year to date (0.880) are unfavorable to target (0.805). There have been 19 hospital acquired infections in FY24. Of these 19 C. Difficile infections, six were likely
Areas of focus to decrease C. Diff are twofold. First, hospital wide education on C. Diff screening, testing and prevention. (See attachment: CdiffHAC2-24 Education Flyer) Second, deployment of enterprise-wide hand hygiene program. A detailed report describing the hand hygiene process improvement initiative is included in the consent agenda portion of the packet as a Quality Committee follow up item.

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

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

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

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

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

B. **Timely**

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

<table>
<thead>
<tr>
<th>What is affecting our TAT?</th>
<th>Description</th>
<th>Corrective Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DxI Downtime</strong> (Analytical Instrument Running Troponin Test x2)</td>
<td>We continue to experience downtimes for our DxI &amp; DxA instrumentation.</td>
<td>Continue to monitor downtimes and escalate to vendor ones that we frequently see.</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td>Increase in TAT may be seen when at least 1 instrument is down or if the line is down/partial down. Details of errors can be sent on request.</td>
<td></td>
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<tr>
<td><strong>DxA Downtime</strong> (Chemistry line processing the specimens for testing on the DxI)</td>
<td></td>
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<tr>
<td><strong>High Troponin Values</strong></td>
<td>Troponin values above a certain threshold is at risk for cross-contamination between subsequent specimens tested.</td>
<td>The manufacturer is aware of this limitation, and we have escalated for a resolution multiple time.</td>
</tr>
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A troponin test measures the levels of troponin proteins in the blood. These proteins are released when the heart muscle has been damaged, such as occurs with a heart attack. The more damage there is to the heart, the greater the amount of troponin there will be in the blood. Outcomes of patients experiencing a heart attack (myocardial infarction) in the ED improve when interventions occur timely. Having the results of troponin blood test within 40 minutes to inform care team of the patient’s cardiac status enables timely intervention.
When identifying a high troponin value, we are required to remove the reagent from the instrument and perform maintenance to eliminate cross-contamination risks. This takes time to perform. Currently no update on their end for a resolution.

### Maintenance

- Maintenance of the DxI or DxA will require periodic downtimes.
- The time for maintenance may be increased due workload as the staff have to juggle both maintenance and releasing of patient results. Delays can be exacerbated with staffing shortages.
- Beckman Coulter to help identify process improvement opportunities in the next month.

### Critical Calls

- Critical calls affect our TAT as we release the result to the patient only after we make the phone call to the care team.
- Depending on the capacity for the unit to quickly answer the call, this will delay our release times (affecting this metric).
- Now, we are calling a large number of troponin results.
- We are working with the cardiovascular service line to adjust the critical call threshold.

### Daily metric for Troponin TAT for December 2023

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

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

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

El Camino Health teams are focused on ensuring patients who have an SVMD primary care provider have timely follow up post discharge. The readmission rates for these patients tracks closely with their ability to be seen timely after discharge. See screenshot below “F/U Office Visits Timeliness After Discharge” from the tableau dashboard created by Steven Sun (Director Clinical Data Analytics) and his team. The top chart shows readmission rates for SVMD patients following hospitalization at ECH. The bottom chart shows the average number of days between discharge and follow up appointment with SVMD primary care physician. Animating the benefits for our patients of being an enterprise, the ECH ambulatory and inpatient teams are collaborating to optimize navigation and integration of care between the hospital and clinic setting.
2. **Risk Adjusted Mortality Index.** Performance for FY24Q2 (1.13) and YTD (1.07) are unfavorable to target (1.00). Mortality index tracks, and for this time frame, is driven by the sepsis mortality.

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

4. **PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV).** Since assuming the inaugural role of Chief Quality Officer for ECH in November 2021, this is the first time I have born witness to a cesarean section rate of 23.2% for nulliparous women having a singleton vertex pregnancy! The FY24Q2 performance (23.2%) is favorable to target of 23.9%. The maternal child health service line is a leader in recognizing and addressing the cultural norms
and expectations of our patients in how they view, engage with and approach health care. Greater than 63% of patients who deliver at ECH are Asian. In our experience, South Asian patients have a low tolerance for the uncertainties, risks, and pain involved with a vaginal delivery and low threshold for requesting a cesarean section. The MCH team, in recognition of the preferences and perspectives of our South Asian maternity patients, has created a culturally sensitive and clinically appropriate pre-natal childbirth education program for S. Asian expectant families. Please see attachment 4, *Health Pregnancy for South Asian Families*.

**D. Efficient**

1. **Length of Stay O/E (LOS O/E).** Length of stay is a measure of operational efficiency. The quality of care a patient receives is reliant on the navigation, coloration and efficiency achieved through operational excellence. Having timely, coordinated, and appropriate care has a profound impact on the overall quality of care our patients receive. Performance YTD (1.20) is unfavorable to target (1.15). A formidable challenge to decreasing length of stay for patients whose discharge disposition is a skilled nursing facility (SNF) are the barriers payors have in place to authorize timely discharge to a SNF. Our teams optimizing care coordination within our system to decrease length of stay. Here are specific interventions in place:

   - We have created a centralized care plan in Epic that pulls together important information about the patients care plan. Information includes the medical care plan for the day, rehab recommendations, discharge destination, social drivers of health, and estimated date of discharge. This tool allows the care team to obtain pertinent information in a timely way without having to dig through the chart. Additionally, we are tracking delays to obtain more insight into the primary reasons for delays in patient throughput.

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

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

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

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

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

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

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

F. Other Measures

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

Attachments:

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

**Works Cited**
**FY24 Enterprise Quality, Safety and Experience Dashboard**

**December 2023** (unless other specified)

**Month to Board Quality Committee:**

**February 2024**

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<table>
<thead>
<tr>
<th>Measure</th>
<th>FY24 Performance</th>
<th>Baseline (FY23 Actual)</th>
<th>FY24 Target</th>
<th>Trend</th>
<th>FYTD or Rolling 12 Month Average</th>
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<tr>
<td><strong>Latest Month</strong></td>
<td>FYTD</td>
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<tr>
<td><em>Organizational Goal</em></td>
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</tr>
<tr>
<td>HAC Index 2.0</td>
<td>1.248</td>
<td>1.300</td>
<td>1.238</td>
<td>1.201 (3.0% ↓)</td>
<td></td>
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<tr>
<td>Latest Month:</td>
<td>December 2023</td>
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<tr>
<td><strong>Latest Month</strong></td>
<td>FYTD</td>
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</tr>
<tr>
<td>C. Diff</td>
<td>3 cases</td>
<td>3.17 cases/mo</td>
<td>2.92 cases/mo</td>
<td>2.83 cases/mo</td>
<td></td>
</tr>
<tr>
<td>Latest Month:</td>
<td>December 2023</td>
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<td>FYTD</td>
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<td></td>
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<tr>
<td>CAUTI</td>
<td>1 cases</td>
<td>1.50 cases/mo</td>
<td>1.08 cases/mo</td>
<td>1.05 cases/mo</td>
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</tr>
<tr>
<td>Latest Month:</td>
<td>December 2023</td>
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Quality Department | Note: updated as of January 23, 2024
### FY24 Enterprise Quality, Safety and Experience Dashboard

**December 2023** (unless other specified)

**Month to Board Quality Committee:**
**February 2024**

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<thead>
<tr>
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<tr>
<td><strong>HAC Component</strong></td>
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</tr>
<tr>
<td>Central Line Associated Blood Stream Infection (CLABSI)</td>
<td>Latest Month: December 2023</td>
<td>1 cases</td>
<td>0.17 cases/mo</td>
<td>0.67 cases/mo</td>
<td>0.65 cases/mo</td>
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<tr>
<td>non-ventilator Hospital-Acquired Pneumonia (nvHAP)</td>
<td>Latest Month: December 2023</td>
<td>1 cases</td>
<td>2.50 cases/mo</td>
<td>2.00 cases/mo</td>
<td>1.94 cases/mo</td>
</tr>
<tr>
<td>Surgical Site Infections (SSI)</td>
<td>Latest Month: December 2023</td>
<td>1 cases</td>
<td>2.83 cases/mo</td>
<td>2.50 cases/mo</td>
<td>2.42 cases/mo</td>
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**Quality Department | Note : updated as of January 23, 2024**
### FY24 Enterprise Quality, Safety and Experience Dashboard

**December 2023** (unless other specified)

#### Measure

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<td>FY24 Actual</td>
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<td>滚动12个月平均率 (Rolling 12 Month Average Rate)</td>
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<tr>
<td></td>
<td>滚动12个月移动平均 (12 Month Moving Average)</td>
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</tbody>
</table>

#### Serious Safety Event Rate (SSER)

- **Latest Month:** October 2023
- **FY24 Performance:** 1 events
- **FY23 Actual:** 1.26 (9/71355)
- **FY 24 Target:** 1.93 (41/212460)
- **Rolling 12 Month Average Rate:** n/a

#### Readmission Index (All Patient All Cause Readmit)

- **Latest Month:** November 2023
- **Observed / Expected:** 0.95 (7.17%/7.58%)
- **Premier Care Sciences Standard RA:** 1.13 (9.02%/7.95%)
- **FY 24 Target:** 1.07 (8.47%/7.94%)
- **Rolling 12 Month Average (O/E):** 1.00

#### Mortality Index

- **Latest Month:** December 2023
- **Observed / Expected:** 1.22 (2.78%/2.28%)
- **Premier Care Sciences Standard RA:** 1.07 (2.04%/1.91%)
- **FY 24 Target:** 1.13 (2.21%/1.96%)
- **Rolling 12 Month Average (O/E):** 1.00

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

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### Sepsis Mortality Index

**Observed / Expected**  
Premier Care Sciences Standard RA

<table>
<thead>
<tr>
<th>Latest Month</th>
<th>FY23 Actual</th>
<th>FY24 Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2023</td>
<td>1.20 (13.73% / 11.44%)</td>
<td>1.21 (14.07% / 11.59%)</td>
<td>1.00</td>
</tr>
</tbody>
</table>

![Graph showing O/E trend over time](image)

**Latest Month:**  
December 2023

**12 Month Moving Average (O/E)**

- January 23: 1.48 (18.13% / 12.26%)
- February 23: 1.20 (13.73% / 11.44%)
- March 23: 1.21 (14.07% / 11.59%)
- April 23: 1.00
- May 23: 1.30
- June 23: 1.50
- July 23: 1.70
- August 23: 0.90
- September 23: 0.85
- October 23: 1.15
- November 23: 1.30
- December 23: 1.10

**Trend:**
- Average: 1.21
- Latest Month: December 2023

**12 Month Rolling Average (Rate)**

- December 22: 22.9%
- January 23: 26.0%
- February 23: 26.0%
- March 23: 26.0%
- April 23: 22.7%
- May 23: 62.7%
- June 23: 62.7%
- July 23: 62.7%
- August 23: 62.7%
- September 23: 62.7%
- October 23: 62.7%
- November 23: 62.7%

**PC-02: Cesarean Birth**

<table>
<thead>
<tr>
<th>Latest Month</th>
<th>FY23 Actual</th>
<th>FY24 Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2023</td>
<td>22.3% (47/211)</td>
<td>25.0% (7/28)</td>
<td>23.9% (FY24 ENT Target)</td>
</tr>
</tbody>
</table>

**Latest Month:**  
November 2023

**12 Month Rolling Average (Rate)**

- December 22: 55.0%
- January 23: 60.0%
- February 23: 65.0%
- March 23: 70.0%
- April 23: 75.0%
- May 23: 80.0%
- June 23: 85.0%
- July 23: 90.0%
- August 23: 95.0%
- September 23: 100.0%
- October 23: 105.0%
- November 23: 110.0%

**PC-05: Exclusive Breast Milk Feeding**

<table>
<thead>
<tr>
<th>Latest Month</th>
<th>FY23 Actual</th>
<th>FY24 Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2023</td>
<td>69.3% (242/349)</td>
<td>67.7% (210/310)</td>
<td>65.1% (FY24 ENT &amp; MV Target)</td>
</tr>
</tbody>
</table>

**Latest Month:**  
November 2023

**12 Month Rolling Average (Rate)**

- December 22: 50.0%
- January 23: 55.0%
- February 23: 60.0%
- March 23: 65.0%
- April 23: 70.0%
- May 23: 75.0%
- June 23: 80.0%
- July 23: 85.0%
- August 23: 90.0%
- September 23: 95.0%
- October 23: 100.0%
- November 23: 105.0%
### FY24 Enterprise Quality, Safety and Experience Dashboard

**December 2023** (unless other specified)

#### Measure | FY24 Performance | Baseline | FY24 Target | Trend | FYTD or Rolling 12 Month Average
--- | --- | --- | --- | --- | ---
| **Latest Month** | **FYTD** |
| Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise) | MV: 172 mins | MV: 177 mins | MV: 194 mins | MV: 191 mins |
| **Latest Month:** December 2023 | ENT: 152 mins | ENT: 156 mins | ENT: 168 mins | ENT: 165 mins |

- **12 Month Rolling Average (mins)**
  - Average: 161
  - Latest Month: December 2023

#### Organizational Goal
- **IP Units - HCAHPS LTR**
  - Top Box Rating of "Yes, Definitely Likely to Recommend" %, Adjusted
  - **Latest Month:** December 2023
  - **Score**
    - ENT: 78.6
    - LG: 82.1
    - MV: 78.5
    - Average: 76.4

- **IP MCH - HCAHPS LTR**
  - Top Box Rating of "Yes, Definitely Likely to Recommend" %, Adjusted
  - **Latest Month:** December 2023
  - **Score**
    - ENT: 82.8
    - LG: 81.5
    - MV: 75.0
    - Average: 75.0

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

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### FY24 Enterprise Quality, Safety and Experience Dashboard

**December 2023** (unless other specified)

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<th>Trend</th>
<th>FYTD or Rolling 12 Month Average</th>
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<tbody>
<tr>
<td>ED Likelihood to Recommend (Top Box Rating of 'Yes, Definitely Likely to Recommend')</td>
<td>71.6</td>
<td>76.2</td>
<td>71.7</td>
<td>71.7</td>
<td>12 Month Moving Average (Score)</td>
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<td>Latest Month: December 2023</td>
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*Organizational Goal ECHMN Likelihood to Recommend (Top Box Rating of 'Yes, Definitely Likely to Recommend') %, Adjusted |

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<thead>
<tr>
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<th>FY24 Performance</th>
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<th>Trend</th>
<th>FYTD or Rolling 12 Month Average</th>
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<tr>
<td>ECHMN Likelihood to Recommend (Top Box Rating of 'Yes, Definitely Likely to Recommend')</td>
<td>83.4</td>
<td>82.1</td>
<td>82.7</td>
<td>81.3</td>
<td>12 Month Moving Average (Score)</td>
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<td>Latest Month: December 2023</td>
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Quality Department | Note: updated as of January 23, 2024
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<th>Measure</th>
<th>Definition Owner</th>
<th>Metric Definition</th>
<th>Data Source</th>
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<tr>
<td>*Organizational Goal HAC Index 2.0</td>
<td>H. Beeman, MD</td>
<td>For FY24, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (4) key inpatient safety events. The elements of the composite are weighted as noted: Clostridium difficile infections (C-Diff) 25%, Catheter Associated Urinary Tract Infection (CAUTI) 25%, Central Line Associated Blood Stream Infection (CLABSI) 25%, and non-ventilator hospital-acquired pneumonia (nvHAP) 25%,</td>
<td>See below</td>
</tr>
<tr>
<td>HAC Component Clostridium Difficile Infections (C-Diff)</td>
<td>C. Nalesnik</td>
<td>1) Based on NHSN defined criteria 2) Exclusions: ED &amp; OP</td>
<td>Numerator: Infection control Dept. Denominator: EPIC Report</td>
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Quality Department | Note: updated as of January 23, 2024
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<th>Definition Owner</th>
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<tbody>
<tr>
<td><strong>HAC Component</strong>&lt;br&gt;Central Line&lt;br&gt;Associated Blood Stream Infection (CLABSI)</td>
<td>C. Nalesnik</td>
<td>1) Based on NHSN defined criteria&lt;br&gt;2) Exclusions: ED &amp; OP</td>
<td>Numerator: Infection control Dept.&lt;br&gt;Denominator: EPIC Report</td>
</tr>
<tr>
<td><strong>HAC Component</strong>&lt;br&gt;non-ventilator&lt;br&gt;Hospital-Acquired Pneumonia (nvHAP)</td>
<td>C. Delogramatic</td>
<td>1) Internal metric: Inpatient non-ventilator hospital-acquired pneumonia cases.&lt;br&gt;2) Numerator inclusions: inpatients (18+ yrs) w/ a specified pneumonia diagnosis code(s) with POA (present on admission) status of &quot;N&quot; (acquired during the hospital encounter), that is unrelated to mechanical ventilation; monthly, cases are reviewed &amp; confirmed by the nvHAP workgroup.&lt;br&gt;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&amp;D, 7427 PACU&lt;br&gt;4) Latency: periodic; corrections may change previously reported results.</td>
<td>EPIC Clarity data warehouse;&lt;br&gt;Numerator identified by nvHAP workgroup;&lt;br&gt;Denominator: EPSI patient days&lt;br&gt;nvHAP Tableau Dashboard maintained by: Mohsina Shakir</td>
</tr>
<tr>
<td><strong>Surgical Site Infections (SSI)</strong></td>
<td>C. Nalesnik</td>
<td>1) Based on NHSN defined criteria&lt;br&gt;2) Inclusions: Surgical cases categorized with either a “clean wound class” or “clean-contaminated wound class”&lt;br&gt;3) Exclusions: surgical cases with a wound class of “contaminated” or “dirty”.&lt;br&gt;4) SSIs that are classified: “deep-incisional” and “organ-space” are reportable.&lt;br&gt;5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.</td>
<td>Numerator: Infection control Dept.&lt;br&gt;Denominator: EPIC Report</td>
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<tr>
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<td>Metric Definition</td>
<td>Data Source</td>
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</table>
| 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 $\leq$ zero.  
New classification rules in effect as of 7/1/22 | HPI Systems                                |
| Readmission Index (All Patient All Cause Readmit) | 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               |
| Mortality Index                              | 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 $\leq$ to zero. | Premier Quality Advisor               |
<table>
<thead>
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</table>
| Sepsis Mortality Index                      | J. Harkey,       | 1) Numerator inclusions: Patient Type = Inpatient, Prin or 2nd diagnosis of sepsis & age 18+ yrs  
| Observed / Expected                         | H. Beeman, MD    | 2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB)                                                                                                        | Premier Quality Advisor |
|                                             |                  | For the trended graph: UCL & LCL are 2+/− the Standard Deviation from the average. LCL is set to ‘0’ if value < = zero.                                                                                          |                       |
| 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  
<p>|                                             |                  | 2) <strong>Denominator</strong>: Single term newborns discharged alive from the hospital                                                                                                                                   | CMQCC                 |</p>
<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition Owner</th>
<th>Metric Definition</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)</td>
<td>J. Baluom</td>
<td>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 (S0) (ADT_ARRIVAL_DTTM in Clarity “F_ED_ENCOUNTERS” table) ED Departure Time - “ED_Departure_DTTM” in Clarity “F_ED_ENCOUNTERS” table</td>
<td>EDSBAR Tableau Dashboard; EDOC Monthly Meeting Dashboard</td>
</tr>
</tbody>
</table>

*Organizational Goal

**IP Units - HCAHPS LTR**

Top Box Rating of ‘Yes, Definitely Likely to Recommend’ %, Adjusted

C. Cunningham

2) Inclusions: Inpatient nursing units; excludes: MBU.
3) Data run criteria, ‘Top Box, Received Date, and Adjusted’

For the trended graph: UCL & LCL are 2 +/- the Standard Deviation from the average. LCL is set to ‘0’ if value <= zero.

HCAHPS

**IP MCH - HCAHPS LTR**

Top Box Rating of ‘Yes, Definitely 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

Quality Department | Note: updated as of January 23, 2024
## FY24 Enterprise Quality, Safety and Experience Dashboard

**December 2023** (unless other specified)

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

### Measure | Definition Owner | Metric Definition | Data Source
---|---|---|---
| ED Likelihood to Recommend Top Box Rating of ‘Yes, Definitely Likely to Recommend’ %, Adjusted | C. Cunningham | ED Likelihood to Recommend - PressGaney data (not part of HCAHPs)
Data run criteria, ‘Top Box, Received Date, and Adjusted’

For the Trended graph: UCL and LCL are 2 +/- the Standard Deviation from the average. LCL is set to ‘0’ if value < = zero. | Press Ganey

| *Organizational Goal ECHMNL Likelihood to Recommend Top Box Rating of ‘Yes, Definitely Likely to Recommend’ %, Adjusted | C. Cunningham | Switched Vendor NRC to PressGaney in January 2022. Started reporting in FY 23 dashboards ‘Top Box, Received Date, and Unadjusted’

For the trended graph: UCL & LCL are 2 +/- the Standard Deviation from the average. LCL is set to ‘0’ if value < = zero. | Press Ganey

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

Quality Department | Note: updated as of January 23, 2024
## FY24 Quarterly Board Quality Dashboard (STEEEP)

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Metric</th>
<th>Past Performance</th>
<th>Baseline</th>
<th>Target</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>FY23 Q1</td>
<td>FY23 Q2</td>
<td>FY23 Q3</td>
<td>FY23 Q4</td>
</tr>
<tr>
<td>Safe Care</td>
<td>HAC Index 2.0 Score</td>
<td>1.358</td>
<td>1.451</td>
<td>1.238</td>
<td>0.861</td>
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<tr>
<td></td>
<td>HAC Component: Cdiff Weighted (25%) Rate (per 10,000 Patient Days)</td>
<td>0.627</td>
<td>1.165</td>
<td>0.874</td>
<td>0.629</td>
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<tr>
<td></td>
<td>HAC Component: CAUTI Weighted (25%) Rate (per 1,000 Urinary Catheter Days)</td>
<td>0.136</td>
<td>0.162</td>
<td>0.218</td>
<td>0.177</td>
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<tr>
<td></td>
<td>HAC Component: CLABSI Weighted (25%) Rate (per 1,000 Central Line Days)</td>
<td>0.511</td>
<td>0.000</td>
<td>0.080</td>
<td>0.000</td>
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<tr>
<td></td>
<td>HAC Component: nvHAP Weighted (25%) Rate (per 1,000 Patient Days)</td>
<td>0.084</td>
<td>0.124</td>
<td>0.066</td>
<td>0.055</td>
</tr>
<tr>
<td></td>
<td>SSI Rate (per 100 surgical procedures) (not part of HAC index)</td>
<td>0.314</td>
<td>0.552</td>
<td>0.196</td>
<td>0.463</td>
</tr>
<tr>
<td>Timely</td>
<td>Lab STAT Troponin TAT for ED (received to verification)</td>
<td>93.8%</td>
<td>88.8%</td>
<td>70.9%</td>
<td>78.0%</td>
</tr>
<tr>
<td></td>
<td>Imaging TAT: ED including Xray (target = % completed ≤ 45 min)</td>
<td>78.4%</td>
<td>78.3%</td>
<td>78.3%</td>
<td>77.0%</td>
</tr>
<tr>
<td>Effective</td>
<td>Risk Adjusted Readmissions Index</td>
<td>1.05</td>
<td>1.18</td>
<td>1.05</td>
<td>1.09</td>
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<tr>
<td></td>
<td>Risk Adjusted Mortality Index</td>
<td>1.03</td>
<td>1.14</td>
<td>1.19</td>
<td>1.14</td>
</tr>
<tr>
<td></td>
<td>RiskAdjusted Sepsis Mortality Index</td>
<td>1.02</td>
<td>1.37</td>
<td>1.26</td>
<td>1.15</td>
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<tr>
<td></td>
<td>PC-02 NTSV C-Section</td>
<td>28.8%</td>
<td>24.7%</td>
<td>24.0%</td>
<td>30.2%</td>
</tr>
<tr>
<td>Eff-Guardian</td>
<td>Median Time of Stay O/E</td>
<td>1.19</td>
<td>1.16</td>
<td>1.22</td>
<td>1.19</td>
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<tr>
<td></td>
<td>Length of Stay O/E</td>
<td>174 min</td>
<td>167 min</td>
<td>168 min</td>
<td>164 min</td>
</tr>
<tr>
<td>Equitable</td>
<td>Homeless Discharge Clothing Documentation Compliance</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td></td>
<td>Quality Council Health Equity Item Included in PI efforts (% of depts)</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td></td>
<td>Sepsis Bundle Compliance by Race</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td></td>
<td>Hispanic</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
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<tr>
<td></td>
<td>White</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
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<tr>
<td></td>
<td>Others</td>
<td>----</td>
<td>----</td>
<td>----</td>
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<tr>
<td>Patient-centered</td>
<td>IP Units Enterprise - HCAHPS Likelihood to Recommend</td>
<td>79.9</td>
<td>78.8</td>
<td>76.6</td>
<td>78.4</td>
</tr>
<tr>
<td></td>
<td>ED - Likelihood to Recommend (PG)</td>
<td>70.3</td>
<td>72.3</td>
<td>73.8</td>
<td>70.4</td>
</tr>
<tr>
<td></td>
<td>MCH - HCAHPS Likelihood to Recommend</td>
<td>72.3</td>
<td>72.1</td>
<td>83.7</td>
<td>74.0</td>
</tr>
</tbody>
</table>

Updated: 01/23/24

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

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

**IP Units Enterprise - HCAHPS Likelihood to Recommend**

- 79.9 (FY23 Q4)
- 84.0 (FY24 Q1)

**ED - Likelihood to Recommend (PG)**

- 70.3 (FY23 Q4)
- 77.9 (FY24 Q1)

**MCH - HCAHPS Likelihood to Recommend**

- 72.3 (FY23 Q4)
- 79.7 (FY24 Q1)
## Quality Domain | Metric
---|---
### Safe Care
- **HAC Index 2.0 Score**
  - Metric Definition: This is a composite measure that tracks hospital-level performance improvement related to key patient safety events. The elements of the composite are weighted as follows: C difficile (5%), Central Line Associated Bloodstream Infection (CLABSI) 15%, and non-ventilator hospital-acquired pneumonia (HVAP) 10%.
- **HAC Component: CAUTI Weighted (15%) Rate (per 1,000 Catheter Days)**
  - Metric Definition: This metric is based on CMS's definitions, including infections in patients with a urinary catheter, in patients with a urinary catheter, and in patients with an indwelling urinary catheter.
- **HAC Component: mVAP Weighted (15%) Rate (per 1,000 Patient Days)**
  - Metric Definition: This metric is based on CMS's definitions, including infections in patients with a ventilator, in patients with a ventilator, and in patients with an indwelling urinary catheter.
- **Risk Adjusted Mortality Index**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.
- **Risk Adjusted Readmissions Index**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.
- **Risk Adjusted Sepsis Mortality Index**
  - Metric Definition: This metric is based on NHSN defined criteria, including infections in patients with severe sepsis.
- **PC-02 NT(h)SV C-section**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.
- **Length of Stay O/E**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.
- **Median Time from ED Arrival to ED Departure (Enterprise)**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.
- **Homeless Discharge Clothing Documentation Compliance**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.
- **Sepsis Bundle Compliance by Race**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.
- **IP Units Enterprise - HCAHPS Likelihood to Recommend**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.
- **ED - Likelihood to Recommend (PG)**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.
- **MCH - HCAHPS Likelihood to Recommend**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.

### Timely
- **Lab STAT TAT for ED (received to verification)**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.
- **Imaging TAT: ED including Xray (target = % completed ≤ 45 min)**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.
- **Medstat TAT for ED (received to verification)**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.
- **Backlog STAT TAT for ED (received to verification)**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.

### Effective
- **Quality Council Health Equity Item Included in PI efforts (in % of departments)**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.
- **Sepsis Bundle Compliance by Race**
  - Metric Definition: This metric is based on Premier's Care Sciences Standard Practice RA for expected risk and includes Patient Type = Inpatient, Excludes cases discharged from ED, then readmitted to the other hospital in 30 days.
HAC-A-Thon: C. diff

Look for the Green, Keep it Clean!

Infection Prevention

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

Refer to Procedure: Management of C. diff Infection
For questions, contact Infection Prevention or Education Department
Healthy Pregnancy for South Asian Families Class Series

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

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

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

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

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

4 Class Series Cost: $100/family
To: Quality, Patient Care and Patient Experience Committee  
From: Holly Beeman, MD, MBA, and Chief Quality Officer  
Date: February 5, 2024  
Subject: Enterprise Quality, Safety and Experience and STEEEP Dashboards through December 2023

**Purpose:**

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

**Situation:**

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

**A. Safe Care**

**Hospital Acquired Condition Index 2.0**

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

<table>
<thead>
<tr>
<th>Component</th>
<th>Denominator</th>
<th>Weighting</th>
<th>Weighted Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>per 1,000 central line days</td>
<td>25%</td>
<td>aa</td>
</tr>
<tr>
<td>CAUTI</td>
<td>per 1,000 catheter days</td>
<td>25%</td>
<td>bb</td>
</tr>
<tr>
<td>C. Diff</td>
<td>per patient days x 10,000</td>
<td>25%</td>
<td>cc</td>
</tr>
<tr>
<td>nvHAP</td>
<td>per patient days x 1,000</td>
<td>25%</td>
<td>dd</td>
</tr>
<tr>
<td>SUM</td>
<td>SUM</td>
<td>SUM</td>
<td>HAC Index</td>
</tr>
</tbody>
</table>

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

1.1. **C. Difficile Infection:** The C. Diff rate per patient days x 10,000 (1.112) for the second quarter and year to date (0.880) are unfavorable to target (0.805). There have been 19 hospital acquired infections in FY24. Of these 19 C. Difficile infections, six were likely
Areas of focus to decrease C. Diff are twofold. First, hospital wide education on C. Diff screening, testing and prevention. (See attachment: CdiffHAC2-24 Education Flyer) Second, deployment of enterprise-wide hand hygiene program. A detailed report describing the hand hygiene process improvement initiative is included in the consent agenda portion of the packet as a Quality Committee follow up item.

1.2. **Catheter Associated Urinary Tract Infection (CAUTI):** The rate of catheter associated urinary tract infection per catheter days for Q2 (0.192) is significantly improved from Q1 (0.356) and is approaching target (0.166). As of January 29, 2024, it has been 56 days since the last CAUTI in Mountain View and 176 days since the last CAUTI in Los Gatos. There have been nine CAUTI year to date with a goal to have less than twelve for the fiscal year. There were four infections in July, and one per month in August through December 2023. Eight of the nine patients with CAUTI were profoundly ill and unstable resulting in an ICU stay and close fluid management via prolonged utilization of a urinary catheter (> 3 days). Having too much or too little intravascular fluid can result in catastrophic damage to the lungs, kidneys, and heart. Close fluid management involves meticulous measurement of fluids going in and fluid
going out (urine). The most accurate way to monitor urine output to be accurate to the milliliter is via an indwelling urinary catheter. Process improvement foci to reduce CAUTI are 1. Remove catheters as soon as possible when clinically appropriate, and 2. Ensure insertion and maintenance best practices are followed. To achieve shorter catheter duration, our infection prevention team rounds on every single patient with a catheter in for greater than three days and collaborates with the nurse and physician to review indications for the catheter and direct attention to the importance of removing the catheter as soon as clinically appropriate. This intervention is likely contributing the improved performance in the second quarter of FY24. Optimizing catheter insertion and maintenance performance has been achieved through partnership amongst our Infection Prevention team, unit champions and BARD™, the vendor who provides our catheters. We requested an independent audit from BARD™ of our catheter practices in August 2023 with a re-visit and audit in December 2023. There has been significant improvement in the 4-month interval between audits. The results are depicted in the bar graph below which illustrates our percentile ranking compared to other like hospitals in catheter best practices. You will appreciate that the domain of catheter duration is where we continue to have the greatest opportunity. This informs our focus on removing catheters timely when clinically appropriate. “When in doubt, take it out!”

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

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

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

**B. Timely**

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

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

---

1 A troponin test measures the levels of troponin proteins in the blood. These proteins are released when the heart muscle has been damaged, such as occurs with a heart attack. The more damage there is to the heart, the greater the amount of troponin there will be in the blood. Outcomes of patients experiencing a heart attack (myocardial infarction) in the ED improve when interventions occur timely. Having the results of troponin blood test within 40 minutes to inform care team of the patient’s cardiac status enables timely intervention.
When identifying a high troponin value, we are required to remove the reagent from the instrument and perform maintenance to eliminate cross-contamination risks. This takes time to perform. Currently no update on their end for a resolution.

**Maintenance**

- Maintenance of the DxI or DxA will require periodic downtimes.
  - The time for maintenance may be increased due workload as the staff have to juggle both maintenance and releasing of patient results. Delays can be exacerbated with staffing shortages.
- Beckman Coulter to help identify process improvement opportunities in the next month.

**Critical Calls**

- Critical calls affect our TAT as we release the result to the patient only after we make the phone call to the care team.
  - Depending on the capacity for the unit to quickly answer the call, this will delay our release times (affecting this metric).
- Now, we are calling a large number of troponin results.
  - We are working with the cardiovascular service line to adjust the critical call threshold.

### Daily metric for Troponin TAT for December 2023

![Daily metric for Troponin TAT for December 2023](image)

---

2. **Imaging Turnaround Time: ED including X Ray (target + % completed <= 45 minutes).**

Performance for Q2 (76.5%) and YTD (76.4%) are **unfavorable** to target (84%). Root cause of the delays relates to the suboptimal performance of the ‘night hawk’ radiology vendor who performs readings for the hospitals after hours. A transition to the new nighttime partner will take effect February 13, 2024. Within 3-months of this transition, we anticipate a significant improvement (decrease) in reading times.
C. Effective

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

El Camino Health teams are focused on ensuring patients who have an SVMD primary care provider have timely follow up post discharge. The readmission rates for these patients tracks closely with their ability to be seen timely after discharge. See screenshot below “F/U Office Visits Timeliness After Discharge” from the tableau dashboard created by Steven Sun (Director Clinical Data Analytics) and his team. The top chart shows readmission rates for SVMD patients following hospitalization at ECH. The bottom chart shows the average number of days between discharge and follow up appointment with SVMD primary care physician. Animating the benefits for our patients of being an enterprise, the ECH ambulatory and inpatient teams are collaborating to optimize navigation and integration of care between the hospital and clinic setting.
2. Risk Adjusted Mortality Index. Performance for FY24Q2 (1.13) and YTD (1.07) are unfavorable to target (1.00). Mortality index tracks, and for this time frame, is driven by the sepsis mortality.

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

4. PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV). Since assuming the inaugural role of Chief Quality Officer for ECH in November 2021, this is the first time I have born witness to a cesarean section rate of 23.2% for nulliparous women having a singleton vertex pregnancy! The FY24Q2 performance (23.2%) is favorable to target of 23.9%. The maternal child health service line is a leader in recognizing and addressing the cultural norms
and expectations of our patients in how they view, engage with and approach health care. Greater than 63% of patients who deliver at ECH are Asian. In our experience, South Asian patients have a low tolerance for the uncertainties, risks, and pain involved with a vaginal delivery and low threshold for requesting a cesarean section. The MCH team, in recognition of the preferences and perspectives of our South Asian maternity patients, has created a culturally sensitive and clinically appropriate pre-natal childbirth education program for S. Asian expectant families. Please see attachment 4, Health Pregnancy for South Asian Families.

D. Efficient

1. **Length of Stay O/E (LOS O/E).** Length of stay is a measure of operational efficiency. The quality of care a patient receives is reliant on the navigation, coloration and efficiency achieved through operational excellence. Having timely, coordinated, and appropriate care has a profound impact on the overall quality of care our patients receive. Performance YTD (1.20) is unfavorable to target (1.15). A formidable challenge to decreasing length of stay for patients whose discharge disposition is a skilled nursing facility (SNF) are the barriers payors have in place to authorize timely discharge to a SNF. Our teams our optimizing care coordination within our system to decrease length of stay. Here are specific interventions in place:

- We have created a centralized care plan in Epic that pulls together important information about the patients care plan. Information includes the medical care plan for the day, rehab recommendations, discharge destination, social drivers of health, and estimated date of discharge. This tool allows the care team to obtain pertinent information in a timely way without having to dig through the chart. Additionally, we are tracking delays to obtain more insight into the primary reasons for delays in patient throughput.

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

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

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

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

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

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

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

F. Other Measures

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

Attachments:

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

**Works Cited**
## FY24 Enterprise Quality, Safety and Experience Dashboard

**December 2023** (unless other specified)

### Month to Board Quality Committee: February 2024

<table>
<thead>
<tr>
<th>Measure</th>
<th>FY24 Performance</th>
<th>Baseline FY23 Actual</th>
<th>FY 24 Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Organizational Goal HAC Index 2.0</em></td>
<td>1.284</td>
<td>1.300</td>
<td>1.238</td>
<td>1.201 (3.0% ↓)</td>
</tr>
</tbody>
</table>

**Latest Month:** December 2023

<table>
<thead>
<tr>
<th>HAC Component</th>
<th>FY24 Performance</th>
<th>Baseline FY23 Actual</th>
<th>FY 24 Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clostridium Difficile Infections (C-Diff)</td>
<td>3 cases</td>
<td>3.17 cases/mo</td>
<td>2.92 cases/mo</td>
<td>2.83 cases/mo</td>
</tr>
</tbody>
</table>

**Latest Month:** December 2023

<table>
<thead>
<tr>
<th>HAC Component</th>
<th>FY24 Performance</th>
<th>Baseline FY23 Actual</th>
<th>FY 24 Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheter Associated Urinary Tract Infection (CAUTI)</td>
<td>1 cases</td>
<td>1.50 cases/mo</td>
<td>1.08 cases/mo</td>
<td>1.05 cases/mo</td>
</tr>
</tbody>
</table>

**Latest Month:** December 2023

Quality Department | Note: updated as of January 23, 2024
### FY24 Enterprise Quality, Safety and Experience Dashboard

**December 2023** (unless other specified)

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

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

- **Total Cases in FY24**
  - **Target < 7.76 total cases in FY24**
  - **Target < 19.4 total cases in FY24**
  - **Target < 27.16 total cases in FY24**
FY24 Enterprise Quality, Safety and Experience Dashboard

December 2023 (unless other specified)

Month to Board Quality Committee:
January 2024

Quality Department | Note: updated as of January 23, 2024
### FY24 Enterprise Quality, Safety and Experience Dashboard

**December 2023 (unless other specified)**

#### Sepsis Mortality Index

**Observed / Expected**
Premier Care Sciences Standard RA

<table>
<thead>
<tr>
<th>Latest Month:</th>
<th>FY23 Actual</th>
<th>FY24 Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2023</td>
<td>1.48 (18.13% / 12.26%)</td>
<td>1.21 (14.07% / 11.59%)</td>
<td>1.00</td>
</tr>
</tbody>
</table>

**12 Month Moving Average (O/E)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 23</td>
<td>1.21</td>
</tr>
<tr>
<td>Feb 23</td>
<td>1.21</td>
</tr>
</tbody>
</table>

**12 Month Rolling Average (Rate)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec 22</td>
<td>23.9%</td>
</tr>
<tr>
<td>Nov 23</td>
<td>22%</td>
</tr>
</tbody>
</table>

#### PC-02 : Cesarean Birth

**Latest Month:** November 2023

<table>
<thead>
<tr>
<th>Measure</th>
<th>FY23 Target</th>
<th>FY24 Target</th>
<th>April 23</th>
<th>May 23</th>
<th>June 23</th>
<th>July 23</th>
<th>Aug 23</th>
<th>Sep 23</th>
<th>Oct 23</th>
</tr>
</thead>
<tbody>
<tr>
<td>MV : 21.9% (40/183)</td>
<td>MV : 26.3% (222/845)</td>
<td>MV : 28.1% (530/1883)</td>
<td>23.9% (FY24 ENT Target)</td>
<td>24% (FY24 ENT Target)</td>
<td>25% (FY24 ENT Target)</td>
<td>26% (FY24 ENT Target)</td>
<td>27% (FY24 ENT Target)</td>
<td>28% (FY24 ENT Target)</td>
<td>29% (FY24 ENT Target)</td>
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</tbody>
</table>

**12 Month Rolling Average (Rate)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec 22</td>
<td>24%</td>
</tr>
<tr>
<td>Nov 23</td>
<td>22%</td>
</tr>
</tbody>
</table>

#### PC-05 : Exclusive Breast Milk Feeding

**Latest Month:** November 2023

<table>
<thead>
<tr>
<th>Measure</th>
<th>FY23 Target</th>
<th>FY24 Target</th>
<th>April 23</th>
<th>May 23</th>
<th>June 23</th>
<th>July 23</th>
<th>Aug 23</th>
<th>Sep 23</th>
<th>Oct 23</th>
</tr>
</thead>
<tbody>
<tr>
<td>MV : 67.7% (210/310)</td>
<td>MV : 66.7% (1023/1534)</td>
<td>MV : 58.1% (1966/3385)</td>
<td>65.1% (FY24 ENT &amp; MV Target)</td>
<td>64% (FY24 ENT &amp; MV Target)</td>
<td>63% (FY24 ENT &amp; MV Target)</td>
<td>62% (FY24 ENT &amp; MV Target)</td>
<td>61% (FY24 ENT &amp; MV Target)</td>
<td>60% (FY24 ENT &amp; MV Target)</td>
<td>59% (FY24 ENT &amp; MV Target)</td>
</tr>
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</table>

**12 Month Rolling Average (Rate)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec 22</td>
<td>62.7%</td>
</tr>
<tr>
<td>Nov 23</td>
<td>61%</td>
</tr>
</tbody>
</table>

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Quality Department | Note: updated as of January 23, 2024
## FY24 Enterprise Quality, Safety and Experience Dashboard

**December 2023** (unless other specified)  

### Measure | FY24 Performance | Baseline FY23 Actual | FY 24 Target | Trend | FYTD or Rolling 12 Month Average
--- | --- | --- | --- | --- | ---
| **Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** | MV : 172 mins | MV : 177 mins | MV : 194 mins | MV : 191 mins | 12 Month Rolling Average (mins)
| Latest Month: December 2023 | ENT : 152 mins | ENT : 156 mins | ENT : 168 mins | ENT : 165 mins | 12 Month Moving Average (Score)

### Organizational Goal

**IP Units - HCAHPS LTR**  
Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted

| Latest Month: December 2023 | ENT : 82.1 | ENT : 78.5 | ENT : 76.4 |

### IP MCH - HCAHPS LTR

Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted

| Latest Month: December 2023 | ENT : 82.8 | ENT : 81.5 | ENT : 75.0 | ENT : 75.0 |

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Quality Department | Note: updated as of January 23, 2024
### FY24 Enterprise Quality, Safety and Experience Dashboard

**December 2023** (unless other specified)

#### FY24 Performance

<table>
<thead>
<tr>
<th>Measure</th>
<th>Latest Month</th>
<th>FYTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Likelihood to Recommend</td>
<td>71.6</td>
<td>76.2</td>
</tr>
<tr>
<td>Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted</td>
<td>71.7</td>
<td>71.7</td>
</tr>
</tbody>
</table>

#### FY24 Baseline

<table>
<thead>
<tr>
<th>Measure</th>
<th>Latest Month</th>
<th>FYTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECHMN Likelihood to Recommend</td>
<td>83.4</td>
<td>82.1</td>
</tr>
<tr>
<td>Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted</td>
<td>82.7</td>
<td>81.3</td>
</tr>
</tbody>
</table>

#### FY24 Target

<table>
<thead>
<tr>
<th>Measure</th>
<th>Latest Month</th>
<th>FYTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 Month Moving Average (Score)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure</th>
<th>Latest Month</th>
<th>FYTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECH Quality Committee Meeting Materials Packet - PUBLIC - February 5, 2024 Page 89 of 127</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure</td>
<td>Definition Owner</td>
<td>Metric Definition</td>
</tr>
<tr>
<td>---------</td>
<td>------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>*Organizational Goal HAC Index 2.0</td>
<td>H. Beeman, MD</td>
<td>For FY24, the HAC (hospital-acquired condition) index is an internally developed composite measure that tracks hospital-level performance improvement related to (4) key inpatient safety events. The elements of the composite are weighted as noted: Clostridium difficile infections (C-Diff) 25%, Catheter Associated Urinary Tract Infection (CAUTI) 25%, Central Line Associated Blood Stream Infection (CLABSI) 25%, and non-ventilator hospital-acquired pneumonia (nvHAP) 25%.</td>
</tr>
<tr>
<td>HAC Component</td>
<td>C. Nalesnik</td>
<td>1) Based on NHSN defined criteria 2) Exclusions: ED &amp; OP</td>
</tr>
<tr>
<td>HAC Component</td>
<td>C. Nalesnik</td>
<td>1) Based on NHSN defined criteria 2) Exclusions: ED &amp; OP</td>
</tr>
</tbody>
</table>

Quality Department | Note: updated as of January 23, 2024
<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition Owner</th>
<th>Metric Definition</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HAC Component</strong></td>
<td></td>
<td><strong>Central Line</strong>&lt;br&gt;<strong>Associated Blood Stream Infection (CLABSI)</strong>&lt;br&gt;1) Based on NHSN defined criteria 2) Exclusions: ED &amp; OP</td>
<td>Numerator: Infection control Dept.  Denominator: EPIC Report</td>
</tr>
<tr>
<td><strong>HAC Component</strong></td>
<td></td>
<td><strong>non-ventilator Hospital-Acquired Pneumonia (nvHAP)</strong> 1) Internal metric: Inpatient: non-ventilator hospital-acquired pneumonia cases. 2) Numerator inclusions: inpatients (≥18yrs) 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 &amp; 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&amp;D, 7427 PACU 4) Latency: periodic; corrections may change previously reported results.</td>
<td>EPIC Clarity data warehouse; Numerator identified by nvHAP workgroup; Denominator: EPSI patient days nvHAP Tableau Dashboard maintained by: Mohsina Shakir</td>
</tr>
<tr>
<td><strong>Surgical Site Infections (SSI)</strong></td>
<td></td>
<td>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.</td>
<td>Numerator: Infection control Dept.  Denominator: EPIC Report</td>
</tr>
<tr>
<td>Measure</td>
<td>Definition Owner</td>
<td>Metric Definition</td>
<td>Data Source</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
</tbody>
</table>
| 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       |
| Readmission Index (All Patient All Cause Readmit) | 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  |
| Mortality Index                              | 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  |

Quality Department | Note: updated as of January 23, 2024
<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition Owner</th>
<th>Metric Definition</th>
<th>Data Source</th>
</tr>
</thead>
</table>
| Sepsis Mortality Index | 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 |
<p>| PC-02 : Cesarean Birth | H. Freeman | 1) <strong>Numerator</strong>: Patients with cesarean births 2) <strong>Denominator</strong>: Nulliparous patients delivered of a live term singleton newborn in vertex presentation | CMQCC |
| PC-05 : Exclusive Breast Milk Feeding | H. Freeman | 1) <strong>Numerator</strong>: Newborns that were fed breast milk only since birth 2) <strong>Denominator</strong>: Single term newborns discharged alive from the hospital | CMQCC |</p>
<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition Owner</th>
<th>Metric Definition</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)</td>
<td>J. Baluom</td>
<td>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</td>
<td>EDSBAR Tableau Dashboard; EDOC Monthly Meeting Dashboard</td>
</tr>
<tr>
<td>*Organizational Goal</td>
<td>C. Cunningham</td>
<td>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’</td>
<td>HCAHPS</td>
</tr>
<tr>
<td>IP MCH - HCAHPS LTR</td>
<td>C. Cunningham</td>
<td>Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, ‘Top Box, Received Date, and Adjusted’</td>
<td>HCAHPS</td>
</tr>
</tbody>
</table>

Quality Department | Note: updated as of January 23, 2024
<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition Owner</th>
<th>Metric Definition</th>
<th>Data Source</th>
</tr>
</thead>
</table>
| ED Likelihood to Recommend  
Top Box Rating of ‘Yes, Definitely Likely to Recommend’ %, Adjusted | C. Cunningham | ED Likelihood to Recommend - Press Ganey data (not part of HCAHPS)  
Data run criteria, ‘Top Box, Received Date, and Adjusted’  
For the Trended graph: UCL and LCL are 2 +/- the Standard Deviation from the average. LCL is set to ‘0’ if value <= zero. | Press Ganey |
| *Organizational Goal  
ECHMNL Likelihood to Recommend  
Top Box Rating of ‘Yes, Definitely Likely to Recommend’ %, Adjusted | C. Cunningham | Switched Vendor NRC to Press Ganey in January 2022. Started reporting in FY 23 dashboards  
‘Top Box, Received Date, and Unadjusted’  
For the trended graph: UCL & LCL are 2 +/- the Standard Deviation from the average. LCL is set to ‘0’ if value <= zero. | Press Ganey |

**Final Notes:**
1. SSER through October 2023
2. Readmissions through November 2023
3. PC-02 & PC-05 through November 2023
4. Updated as of 2024-01-23
## FY24 Quarterly Board Quality Dashboard (STEEP)

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Metric</th>
<th>FY23 Q1</th>
<th>FY23 Q2</th>
<th>FY23 Q3</th>
<th>FY23 Q4</th>
<th>FY24 Q1</th>
<th>FY24 Q2</th>
<th>FY24 Q3</th>
<th>FY24 Q4</th>
<th>FYTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Care</td>
<td>HAC Index 2.0 Score</td>
<td>1.358</td>
<td>1.451</td>
<td>1.238</td>
<td>0.861</td>
<td>1.238</td>
<td>1.201</td>
<td>1.130</td>
<td>1.460</td>
<td>1.300</td>
</tr>
<tr>
<td></td>
<td>HAC Component: Cdiff Weighted (25%) Rate (per 10,000 Patient Days)</td>
<td>0.627</td>
<td>1.165</td>
<td>0.874</td>
<td>0.629</td>
<td>0.830</td>
<td>0.805</td>
<td>0.649</td>
<td>1.112</td>
<td>0.880</td>
</tr>
<tr>
<td></td>
<td>HAC Component: CAUTI Weighted (25%) Rate (per 1,000 urinary Catheter Days)</td>
<td>0.136</td>
<td>0.162</td>
<td>0.218</td>
<td>0.177</td>
<td>0.171</td>
<td>0.166</td>
<td>0.356</td>
<td>0.192</td>
<td>0.277</td>
</tr>
<tr>
<td></td>
<td>HAC Component: CLABSI Weighted (25%) Rate (per 1,000 central line days)</td>
<td>0.511</td>
<td>0.000</td>
<td>0.080</td>
<td>0.000</td>
<td>0.154</td>
<td>0.150</td>
<td>0.000</td>
<td>0.075</td>
<td>0.089</td>
</tr>
<tr>
<td></td>
<td>HAC Component: nhHAP Weighted (25%) Rate (per 1000 patient days)</td>
<td>0.084</td>
<td>0.124</td>
<td>0.066</td>
<td>0.055</td>
<td>0.082</td>
<td>0.080</td>
<td>0.125</td>
<td>0.081</td>
<td>0.103</td>
</tr>
<tr>
<td></td>
<td>ISSI Rate (per 100 surgical procedures) (not part of HAC index)</td>
<td>0.314</td>
<td>0.552</td>
<td>0.196</td>
<td>0.463</td>
<td>0.380</td>
<td>0.369</td>
<td>0.564</td>
<td>0.301</td>
<td>0.431</td>
</tr>
<tr>
<td>Timely</td>
<td>Lab STAT Troponin TAT for ED (received to verification)</td>
<td>93.8%</td>
<td>88.8%</td>
<td>70.9%</td>
<td>78.0%</td>
<td>82.7%</td>
<td>90.0%</td>
<td>84.2%</td>
<td>76.6%</td>
<td>76.4%</td>
</tr>
<tr>
<td></td>
<td>Imaging TAT: ED including Xray (target = % completed ≤ 45 min)</td>
<td>78.4%</td>
<td>78.3%</td>
<td>78.3%</td>
<td>77.0%</td>
<td>78.0%</td>
<td>84.0%</td>
<td>76.3%</td>
<td>76.5%</td>
<td>76.4%</td>
</tr>
<tr>
<td>Effective</td>
<td>Risk Adjusted Readmissions Index</td>
<td>1.05</td>
<td>1.18</td>
<td>1.05</td>
<td>1.09</td>
<td>1.09</td>
<td>1.00</td>
<td>1.14</td>
<td>1.13*</td>
<td>(Oct-Nov)</td>
</tr>
<tr>
<td></td>
<td>Risk Adjusted Mortality Index</td>
<td>1.03</td>
<td>1.14</td>
<td>1.19</td>
<td>1.14</td>
<td>1.13</td>
<td>1.00</td>
<td>1.00</td>
<td>1.13</td>
<td>1.07</td>
</tr>
<tr>
<td></td>
<td>Risk Adjusted Sepsis Mortality Index</td>
<td>1.02</td>
<td>1.37</td>
<td>1.26</td>
<td>1.15</td>
<td>1.20</td>
<td>1.00</td>
<td>1.07</td>
<td>1.32</td>
<td>1.20</td>
</tr>
<tr>
<td></td>
<td>PC-02 NTSV C-Section</td>
<td>28.8%</td>
<td>24.7%</td>
<td>24.0%</td>
<td>30.2%</td>
<td>27.0%</td>
<td>23.9%</td>
<td>26.6%</td>
<td>23.2%</td>
<td>25.2%</td>
</tr>
<tr>
<td>Efficient</td>
<td>Median Time from ED Arrival to ED Departure (Enterprise)</td>
<td>1.19</td>
<td>1.16</td>
<td>1.22</td>
<td>1.19</td>
<td>1.19</td>
<td>1.15</td>
<td>1.19</td>
<td>1.22</td>
<td>1.20</td>
</tr>
<tr>
<td>Homeless</td>
<td>Homeless Discharge Clothing Documentation Compliance</td>
<td>100.0%</td>
<td>53.0%</td>
<td>(14/27)</td>
<td>69.0%</td>
<td>(24/34)</td>
<td>61.0%</td>
<td>(22/36)</td>
<td>66.7%</td>
<td>(22/33)</td>
</tr>
<tr>
<td></td>
<td>Quality Council Health Equity Item included in PI efforts (% of depts)</td>
<td>50.0%</td>
<td>0.0%</td>
<td>(0/3)</td>
<td>33.3%</td>
<td>(2/6)</td>
<td>21.1%</td>
<td>(1/5)</td>
<td>20.0%</td>
<td>(1/5)</td>
</tr>
<tr>
<td>Sepsis Bundle</td>
<td>Asian Sepsis Bundle Compliance by Race</td>
<td>77.8%</td>
<td>75.0%*</td>
<td>(12/16)</td>
<td>75.0%*</td>
<td>(16/22)</td>
<td>79.9%*</td>
<td>(12/16)</td>
<td>76.0%*</td>
<td>(16/21)</td>
</tr>
<tr>
<td></td>
<td>Hispanic Sepsis Bundle Compliance by Race</td>
<td>93.3%</td>
<td>81.3%*</td>
<td>(13/16)</td>
<td>87.5%*</td>
<td>(17/20)</td>
<td>87.1%*</td>
<td>(17/20)</td>
<td>87.1%*</td>
<td>(17/20)</td>
</tr>
<tr>
<td></td>
<td>White Sepsis Bundle Compliance by Race</td>
<td>86.6%</td>
<td>82.8%*</td>
<td>(53/64)</td>
<td>85.1%*</td>
<td>(127/152)</td>
<td>85.1%*</td>
<td>(127/152)</td>
<td>85.1%*</td>
<td>(127/152)</td>
</tr>
<tr>
<td></td>
<td>Others Sepsis Bundle Compliance by Race</td>
<td>61.1%</td>
<td>70.0%*</td>
<td>(27/40)</td>
<td>64.3%*</td>
<td>(34/53)</td>
<td>64.3%*</td>
<td>(34/53)</td>
<td>64.3%*</td>
<td>(34/53)</td>
</tr>
<tr>
<td>Patient-</td>
<td>IP Units Enterprise - HCAHPS Likelihood to Recommend</td>
<td>79.9</td>
<td>78.8</td>
<td>76.6</td>
<td>78.4</td>
<td>78.5</td>
<td>76.4</td>
<td>84.0</td>
<td>80.3</td>
<td>82.1</td>
</tr>
<tr>
<td>Centered</td>
<td>ED - Likelihood to Recommend (PG)</td>
<td>70.3</td>
<td>72.3</td>
<td>73.8</td>
<td>70.4</td>
<td>71.7</td>
<td>71.7</td>
<td>77.9</td>
<td>74.5</td>
<td>76.2</td>
</tr>
<tr>
<td></td>
<td>MCH - HCAHPS Likelihood to Recommend</td>
<td>72.3</td>
<td>72.1</td>
<td>83.7</td>
<td>74.0</td>
<td>75.0</td>
<td>75.0</td>
<td>79.7</td>
<td>83.7</td>
<td>81.5</td>
</tr>
</tbody>
</table>

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

**Updated:** 01/23/24

**STEEP:** Safe Care, Timely, Effective, Efficient, Equitable, Patient-Centered
<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Care</td>
<td></td>
</tr>
<tr>
<td><strong>HAC Index 2.0 Score</strong></td>
<td>2012/13, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital level performance improvement related to 6 key inpatient safety events. The elements of the composite are weighted as noted: Clostridium difficile Infection (C-Diff) 35%, Catheter Associated Urinary Tract Infection (CAUTI) 15%, Central Line Associated Bloodstream Infection (CLABSI) 15%, and non-ventilator hospital acquired pneumonia (VAP) 15%</td>
</tr>
<tr>
<td><strong>HAC Component: C. diff Weighted (35%) Rate (per 10,000 Patient Days)</strong></td>
<td>1) Based on NHSN defined criteria: Inclusions: Inpatient, NICU, Behavioral Health; exclusions: Rehab, NICU, outpatients; EG patients. 2) All positive C. diff Tests/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.</td>
</tr>
<tr>
<td><strong>HAC Component: CAUTI Weighted (15%) Rate (per 1,000 Catheter Days)</strong></td>
<td>1) Based on NHSN defined criteria 2) Exclusions: ED &amp; OP</td>
</tr>
<tr>
<td><strong>HAC Component: CLABSI Weighted (15%) Rate (per 1,000 Central Line Days)</strong></td>
<td>1) Based on NHSN defined criteria 2) Exclusions: ED &amp; OP</td>
</tr>
<tr>
<td><strong>HAC Component: mVAP Weighted (15%) Rate (per 1000 Patient Days)</strong></td>
<td>2) 3-days hospitalization &amp; not receiving mechanical ventilation. Evidence of order or procedure code for chest X-ray or computerized tomography of the chest. Administration of selected antimicrobials (in Table 3) not previously administered in past 2 days and continued for 3 days (changes in antibiotics permitted during the 3 day period so long as each new agent was not used in the preceding 2 days). More detailed and specific definitions can be provided.</td>
</tr>
<tr>
<td><strong>Urgent Care Admission (UCAD)</strong></td>
<td>[1) Based on NHSN defined criteria 2) Exclusions: COPD, COPD, ED patients]</td>
</tr>
<tr>
<td><strong>Risk Adjusted Mortality Index</strong></td>
<td><strong>Metric Definition</strong></td>
</tr>
<tr>
<td><strong>Risk Adjusted Readmissions Index</strong></td>
<td>1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Causes). 2) Based upon Premier’s Care Sciences Standard Practice risk-adjustment + CMS All-Cause 30day readmission methodology (includes cases CMS defines “planned”): 3) Numerator exclusions: Patient Type = Inpatient 4) NOTE: Excludes cases discharged from [2] hospital, then readmitted to the other hospital in [2] days.</td>
</tr>
<tr>
<td><strong>Risk Adjusted Sepsis Mortality Index</strong></td>
<td>1) Numerator inclusions: Patient Type = Inpatient 2) Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation</td>
</tr>
<tr>
<td><strong>ED - Likelihood to Recommend (PG)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Lab STAT Troponin TAT for ED (received to verification)</strong></td>
<td>A metric that assists with ED through put and timely diagnosis of cardiac injury. The measurement begins with a time stamp of the specimen being received in the clinical laboratory and ends with a time stamp of the Troponin result being released to EPIC.</td>
</tr>
<tr>
<td><strong>Imaging TAT: ED including Xray (target = % completed ≤ 45 min)</strong></td>
<td>Imaging TAT Criteria: TAT from Exam NSC to Exam Finalized. Routine exam orders only.</td>
</tr>
<tr>
<td><strong>Length of Stay O/E</strong></td>
<td></td>
</tr>
<tr>
<td><strong>PC-02 NTSV C-Section</strong></td>
<td>1) Based upon Premier’s Care Sciences Standard Practice risk-adjustment for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient; exclusions: Patient Type = Rehab, Psychiatric or Hospice.</td>
</tr>
<tr>
<td><strong>Length of Stay O/E</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Weighted Homeless Discharge Clothing Documentation Compliance</strong></td>
<td>EMFAQS - Homeless Discharge Navigator. Specifically for Clothing documented and compliance. Epic data source.</td>
</tr>
<tr>
<td><strong>Sepsis Bundle Compliance by Race</strong></td>
<td>Sample of patients age ≥ 18 years, presenting in the Emergency Dept or in-patient unit with severe sepsis/septic shock (suspected or known infection, 2+ SIRS, 1 new organ dysfunction). Retrospective or concurrent chart reviews identified from one or more of the following: Emergency Room work up/differential, admitting diagnosis, Sepsis Alert, safety reporting system, MR surveillance, Care reporting. KOD-10 discharge code: Time of Presentation(TOP) time at which all criteria for severe sepsis are present, OR provider documentation of severe sepsis, whichever is earliest. Race is defined as defined of patient registration input, collected &amp; documented in Epic.</td>
</tr>
<tr>
<td><strong>Sepsis Bundle Compliance by Race</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sepsis Bundle Compliance by Race</strong></td>
<td><strong>Sepsis Bundle Compliance by Race</strong></td>
</tr>
<tr>
<td><strong>Sepsis Bundle Compliance by Race</strong></td>
<td><strong>Sepsis Bundle Compliance by Race</strong></td>
</tr>
<tr>
<td><strong>Sepsis Bundle Compliance by Race</strong></td>
<td><strong>Sepsis Bundle Compliance by Race</strong></td>
</tr>
<tr>
<td><strong>Sepsis Bundle Compliance by Race</strong></td>
<td><strong>Sepsis Bundle Compliance by Race</strong></td>
</tr>
<tr>
<td><strong>IP Units Enterprise - HCAHPS Likelihood to Recommend</strong></td>
<td>1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. 2) Inclusions: Inpatient nursing units; excludes: NICU 3) Data run criteria: Top Box, Received Date, and Adjusted.</td>
</tr>
<tr>
<td><strong>ED - likelihood to Recommend (PG)</strong></td>
<td>[1) Used to Recommend - Provider data (not part of HCAHPS) 2) Data run criteria: Top Box, Received Date, and Adjusted]</td>
</tr>
<tr>
<td><strong>MCH - HCAHPS Likelihood to Recommend</strong></td>
<td>Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Mother/Baby Units only. Data run criteria: Top Box, Received Date, and Adjusted]</td>
</tr>
</tbody>
</table>
HAC-A-Thon: C.diff

Look for the Green, Keep it Clean!

Infection Prevention

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

Refer to Procedure: Management of C. diff Infection
For questions, contact Infection Prevention or Education Department
**Prenatal Education | Maternal Child Health**

**Healthy Pregnancy for South Asian Families Class Series**

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

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

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

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

**Sign up for the four-class series via Course Storm:**

**4 Class Series Cost:** $100/family
Purpose:

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

Summary:

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

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

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

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

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

ECHMN has established true north pillars, one of which is quality and service. Starting June 1, 2023, ECHMN changed its quality reporting methodology to calendar year to better align with the Centers for Medicare and Medicaid (CMS) and major health plans/payers. For calendar year 2023, ECHMN has met/exceeded targets in all eight (8) quality metrics. The Network is performing in the 9th and 10th decile in 5 measures with
ECHMN Quarterly Quality Report
February 5, 2024

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

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

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

List of Attachments:

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

Suggested Committee Discussion Questions:

What additional information would be helpful for the ECHB Quality Committee to receive in the quarterly reports from ECHMN?
ECH Quality Committee Meeting
ECHMN Quality Update

February 5, 2024

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

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

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

- **Patient Experience Domain**
  - FY 2024 2nd Quarter Results
Clinical Domain
## Core Quality Measures Results as of CY ending 1/2/24

<table>
<thead>
<tr>
<th>Core Measures</th>
<th>CY 2023 Goal</th>
<th>Current Results</th>
<th>2023 CMS Decile of Current Results</th>
<th>% Needed to be in 10&lt;sup&gt;th&lt;/sup&gt; Decile</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 112 Breast Cancer Screening</td>
<td>7 of 8</td>
<td>8 of 8</td>
<td>9&lt;sup&gt;th&lt;/sup&gt;</td>
<td>&gt;=82.05%</td>
</tr>
<tr>
<td>CMS 122 Diabetes: Hemoglobin A1c poor control&gt;9%</td>
<td>78%</td>
<td>79%</td>
<td>9&lt;sup&gt;th&lt;/sup&gt;</td>
<td>&gt;=82.05%</td>
</tr>
<tr>
<td>(lower number is better)</td>
<td>17%</td>
<td>15%</td>
<td>10&lt;sup&gt;th&lt;/sup&gt;</td>
<td>&lt;=17.07%</td>
</tr>
<tr>
<td>CMS 130 Colorectal Cancer Screening</td>
<td>68%</td>
<td>73%</td>
<td>8&lt;sup&gt;th&lt;/sup&gt;</td>
<td>&gt;=85.69%</td>
</tr>
<tr>
<td>CMS 138 Tobacco - Screening and Cessation Intervention Plan</td>
<td>85%</td>
<td>96%</td>
<td>9&lt;sup&gt;th&lt;/sup&gt;</td>
<td>&gt;=98.33%</td>
</tr>
<tr>
<td>CMS 139 Fall Risk Screening</td>
<td>98%</td>
<td>99%</td>
<td>10&lt;sup&gt;th&lt;/sup&gt;</td>
<td>&gt;=98.92%</td>
</tr>
<tr>
<td>CMS 165 Controlling High Blood Pressure</td>
<td>72%</td>
<td>75%</td>
<td>8&lt;sup&gt;th&lt;/sup&gt;</td>
<td>&gt;=81.35%</td>
</tr>
<tr>
<td>CMS 347 Statin Therapy for ACSVD Patients</td>
<td>86%</td>
<td>86%</td>
<td>10&lt;sup&gt;th&lt;/sup&gt;</td>
<td>&gt;=84.75%</td>
</tr>
<tr>
<td>CMS 68 Reconciliation of Current Medications</td>
<td>98%</td>
<td>98%</td>
<td>7&lt;sup&gt;th&lt;/sup&gt;</td>
<td>&gt;=99.87%</td>
</tr>
</tbody>
</table>
2023 was another strong year for ECHMN Quality, with performance increases from 2022 in 5 of 6 selected metrics and 2023 targets met in 8 of the 8.
Performance Decile for Selected Quality Metrics - Trend Compared to Industry

- Reconciliation of Current Meds
- Breast Cancer Screening
- Diabetes: HbA1c Control<9%
- Colorectal Cancer Screening
- Tobacco Screening
- Fall Risk Screening
- Controlling Blood Pressure
- Statin Therapy

2021 Decile  | 2022 Decile  | 2023 Decile

- 5  | 5  | 9
- 6  | 6  | 10
- 5  | 10 | 10
- 6  | 6  | 8
- 6  | 6  | 9
- 6  | 6  | 10
- 5  | 7  | 8
- 7  | 7  | 10

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

- Received credentialing re-delegation for all health plan with a score of 100%
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- Reviewed and updated the quality policies and procedures
- Submitted our first Medicare Value Pathway (MVP) for calendar year 2023
- Achieved 7 of 8 quality measures
- Developed and implemented emergency flow sheets for the urgent care centers
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Dependable and Convenient Care Results
## Dependable, Convenient and Experience Domain – FY 2024

Results as of

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure</th>
<th>Baseline FY23</th>
<th>FY24 Target</th>
<th>FYTD 24</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dependable and Convenient</strong></td>
<td>Access 3na for Primary Care by Department (in days)</td>
<td>7.5</td>
<td>7.0</td>
<td>9.1</td>
</tr>
<tr>
<td></td>
<td>Access 3na for Specialty Care by Provider (in days)</td>
<td>23.6</td>
<td>22</td>
<td>35.7</td>
</tr>
<tr>
<td></td>
<td>Clinician Response to Patient Messages &lt; 48 hours (in days)</td>
<td>1.6</td>
<td>1.2</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>Experience</strong></td>
<td>Primary Care and Specialty LTR (Likelihood to Recommend)</td>
<td>80.7</td>
<td>81.3</td>
<td>82.1</td>
</tr>
<tr>
<td></td>
<td>Urgent Care LTR (Likelihood to Recommend)</td>
<td>76.1</td>
<td>78.0</td>
<td>78.5</td>
</tr>
<tr>
<td>Measure</td>
<td>Results</td>
<td>Contributing Factors</td>
<td>Action Plan</td>
<td></td>
</tr>
<tr>
<td>------------------------------------</td>
<td>---------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| **Primary Care 3rd Next Available** | 9.1 Days | • Concentrated time off in November and December, due to holiday time out of office  
• Loss of two PCPs and two APCs October - December | • Five PCPs hired September – October; two APCs hired October  
• Continue to recruit PCPs and APCs  
• Shift certain appointments to APCs |
| **Specialty Care 3rd Next Available** | 35.7 Days | • Two PA-Cs hired in two specialties (GI, Ortho Spine)  
• Concentrated time off in November and December, due to holiday time out of office | • Continue to recruit specialists and APCs  
• Increased specialties enabled for automated wait list scheduling  
• Improve quality of referrals sent to specialists with more education on appropriate work up  
• Longer term plan to expand referrals to IPA/Downstream providers with visibility to their soonest available appointments |
| **Clinician Response Time for Messages** | 1.6 Days | • Refill request workflow inflates the average turnaround time | • Refill request workflow is being changed and provider education is being delivered once the change is finalized  
• Education for providers that weekends are included in this metric  
• Continue to recruit three primary care RNs for advice requests and triage needs |
Patient Experience Domain – Results FY2024

<table>
<thead>
<tr>
<th>ENTERPRISE</th>
<th>FY23 (Baseline)</th>
<th>FY24 Target Goals</th>
<th>Jul 23</th>
<th>Aug 23</th>
<th>Sep 23</th>
<th>Oct 23</th>
<th>Nov 23</th>
<th>Dec 23</th>
<th>FYTD</th>
<th>Gap to Baseline</th>
<th>Gap to Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>*ECHMN - All</td>
<td>80.7</td>
<td>81.3</td>
<td>82.2</td>
<td>82.5</td>
<td>79.4</td>
<td>82.9</td>
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<tr>
<td>Primary Care &amp; Specialty Care</td>
<td>27</td>
<td>32</td>
<td>34</td>
<td>35</td>
<td>21</td>
<td>37</td>
<td>32</td>
<td>38</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>10017</td>
<td>-</td>
<td>1286</td>
<td>826</td>
<td>703</td>
<td>697</td>
<td>545</td>
<td>458</td>
<td>4516</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>ECHMN - Primary Care</td>
<td>79.6</td>
<td>80.1</td>
<td>80.6</td>
<td>81.6</td>
<td>77.6</td>
<td>81.3</td>
<td>77.4</td>
<td>77.7</td>
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<td></td>
</tr>
<tr>
<td>5720</td>
<td>-</td>
<td>612</td>
<td>396</td>
<td>304</td>
<td>336</td>
<td>292</td>
<td>238</td>
<td>2178</td>
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<td></td>
</tr>
<tr>
<td>ECHMN - Specialty Care</td>
<td>82.2</td>
<td>82.6</td>
<td>83.7</td>
<td>83.3</td>
<td>80.7</td>
<td>84.5</td>
<td>88.2</td>
<td>89.6</td>
<td>84.3</td>
<td>2.1</td>
<td>1.7</td>
</tr>
<tr>
<td></td>
<td>34</td>
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<td>44</td>
<td>43</td>
<td>26</td>
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<td>77</td>
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<tr>
<td>4297</td>
<td>-</td>
<td>674</td>
<td>430</td>
<td>399</td>
<td>361</td>
<td>254</td>
<td>220</td>
<td>2338</td>
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</tr>
<tr>
<td>ECHMN - Urgent Care</td>
<td>76.1</td>
<td>78.0</td>
<td>77.2</td>
<td>77.6</td>
<td>73.8</td>
<td>80.0</td>
<td>83.3</td>
<td>77.5</td>
<td>78.5</td>
<td>2.4</td>
<td>0.5</td>
</tr>
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<td></td>
<td>36</td>
<td>68</td>
<td>36</td>
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<td>19</td>
<td>53</td>
<td>74</td>
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<td>140</td>
<td>162</td>
<td>178</td>
<td>901</td>
<td></td>
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</tr>
</tbody>
</table>

All Clinics LTR Clinic Top Box e-survey adjusted - * Indicates Incentive Goal

Data as of 1/2/24
Questions?
To: El Camino Hospital Board Quality, Patient Care and Patient Experience Committee (“ECHB Quality Committee”)
From: Ute Burness, RN, VP of Quality, and Shahab Dadjou, President, ECHMN
Date: February 5, 2024
Subject: ECHMN Quarterly Quality Report

Purpose:

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

Summary:

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

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

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

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

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

ECHMN has established true north pillars, one of which is quality and service. Starting June 1, 2023, ECHMN changed its quality reporting methodology to calendar year to better align with the Centers for Medicare and Medicaid (CMS) and major health plans/payers. For calendar year 2023, ECHMN has met/exceeded targets in all eight (8) quality metrics. The Network is performing in the 9th and 10th decile in 5 measures with
plans to improve other core measures from their current 7th and 8th decile. Year over year, there is a consistent pattern of improvement in each of the eight (8) measures since 2021.

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

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

List of Attachments:
PowerPoint background material to pre-read to facilitate the discussion and use as a reference for discussion.

Suggested Committee Discussion Questions:
What additional information would be helpful for the ECHB Quality Committee to receive in the quarterly reports from ECHMN?
ECH Quality Committee Meeting
ECHMN Quality Update

February 5, 2024

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

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

- **Dependable and Convenient Domain**
  - FY 2024 2\textsuperscript{nd} Quarter Results

- **Patient Experience Domain**
  - FY 2024 2\textsuperscript{nd} Quarter Results
Clinical Domain
## Core Quality Measures Results as of CY ending 1/2/24

<table>
<thead>
<tr>
<th>Core Measures</th>
<th>CY 2023 Goal</th>
<th>Current Results</th>
<th>2023 CMS Decile of Current Results</th>
<th>% Needed to be in 10(^{th}) Decile</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 of 8</td>
<td>8 of 8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMS 112 Breast Cancer Screening</td>
<td>78%</td>
<td>79%</td>
<td>9(^{th})</td>
<td>&gt;=82.05%</td>
</tr>
<tr>
<td>CMS 122 Diabetes: Hemoglobin A1c poor control&gt;9% (lower number is better)</td>
<td>17%</td>
<td>15%</td>
<td>10(^{th})</td>
<td>&lt;=17.07%</td>
</tr>
<tr>
<td>CMS 130 Colorectal Cancer Screening</td>
<td>68%</td>
<td>73%</td>
<td>8(^{th})</td>
<td>&gt;=85.69%</td>
</tr>
<tr>
<td>CMS 138 Tobacco - Screening and Cessation Intervention Plan</td>
<td>85%</td>
<td>96%</td>
<td>9(^{th})</td>
<td>&gt;=98.33</td>
</tr>
<tr>
<td>CMS 139 Fall Risk Screening</td>
<td>98%</td>
<td>99%</td>
<td>10(^{th})</td>
<td>&gt;=98.92%</td>
</tr>
<tr>
<td>CMS 165 Controlling High Blood Pressure</td>
<td>72%</td>
<td>75%</td>
<td>8(^{th})</td>
<td>&gt;=81.35%</td>
</tr>
<tr>
<td>CMS 347 Statin Therapy for ACSVD Patients</td>
<td>86%</td>
<td>86%</td>
<td>10(^{th})</td>
<td>&gt;=84.75%</td>
</tr>
<tr>
<td>CMS 68 Reconciliation of Current Medications</td>
<td>98%</td>
<td>98%</td>
<td>7(^{th})</td>
<td>&gt;=99.87%</td>
</tr>
</tbody>
</table>
2023 was another strong year for ECHMN Quality, with performance increases from 2022 in 5 of 6 selected metrics and 2023 targets met in 8 of the 8 Core Quality Measures Year Over Year Trend

<table>
<thead>
<tr>
<th>Metric</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconciliation of Current Meds</td>
<td>89%</td>
<td>93%</td>
<td>98%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>48%</td>
<td>71%</td>
<td>79%</td>
</tr>
<tr>
<td>Diabetes: HBA1c Control&lt;9%</td>
<td>45%</td>
<td>23%</td>
<td>15%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>45%</td>
<td>58%</td>
<td>73%</td>
</tr>
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<tr>
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<td></td>
<td>91%</td>
<td>99%</td>
</tr>
<tr>
<td>Controlling Blood Pressure</td>
<td></td>
<td>63%</td>
<td>62%</td>
</tr>
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<td>Statin Therapy</td>
<td></td>
<td>75%</td>
<td>86%</td>
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Quality Metric Performance by Deciles Year over Year Trend

Performance Decile for Selected Quality Metrics - Trend Compared to Industry

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Dependable and Convenient Care Results
## Dependable, Convenient and Experience Domain – FY 2024 Results as of February 5, 2024

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</tr>
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<td></td>
<td>(Access Third Next Available – Lower is better)</td>
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</tr>
</tbody>
</table>

**Legend:**
- Green: Met Target
- Yellow: Missed Target by < 5%
- Red: Missed Target by > 5%
### Primary Care 3rd Next Available (3NA)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Results</th>
<th>Contributing Factors</th>
<th>Action Plan</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

### Specialty Care 3rd Next Available (3NA)

<table>
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### Clinician Response Time for Messages

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**Dependable, Convenient Domain – Improvement Plan**
## Patient Experience Domain – Results FY2024

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<th>ENTERPRISE</th>
<th>FY23 Baseline</th>
<th>FY24 Target Goals</th>
<th>Jul 23</th>
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<td>32</td>
<td>34</td>
<td>35</td>
<td>21</td>
<td>37</td>
<td>32</td>
<td>38</td>
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*All Clinics LTR Clinic Top Box e-survey adjusted - * Indicates Incentive Goal

Data as of 1/2/24
Questions?