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

Monday, June 3, 2024 – 5:30 pm

El Camino Health | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

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

1-669-900-9128, MEETING CODE: 937 8909 5081#. No participant code. Just press #.

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Quality Committee Meeting Link

Please note that the livestream is for **meeting viewing only** and there is a slight delay; to provide public comment, please use the phone number listed above.

NOTE: In the event that there are technical problems or disruptions that prevent remote public participation, the Chair has the discretion to continue the meeting without remote public participation options, provided that no Board member is participating in the meeting via teleconference.

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Carol Somersille, MD Quality Committee Chair		**5:30 pm**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Carol Somersille, MD Quality Committee Chair	Possible Motion	**5:30 pm**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair	Information	**5:30 pm**
4.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. Written Public Comments *Comments may be submitted by mail to the El Camino Hospital Board Quality Committee at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	Carol Somersille, MD Quality Committee Chair	Information	**5:30 pm**
5.	**CONSENT CALENDAR ITEMS** *Any Committee Member may pull an item for discussion before a motion is made.*	Carol Somersille, MD Quality Committee Chair	Motion Required	**5:37 – 5:57**

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) 988-3218** prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
	a. Approve Minutes of the Open Session of the Quality Committee Meeting (05/06/2024) b. Approve Minutes of the Closed Session of the Quality Committee Meeting (05/06/2024) c. Progress Against FY24 Committee Goals d. FY24 Enterprise Quality Dashboard e. Leapfrog			
6.	**COMMITTEE EXPERTISE REPORT**	Melora Simon Quality Committee Member	Information	**5:57 – 6:07**
7.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Discussion	**6:07– 6:17**
8.	**HEALTH CARE EQUITY**	Shreyas Mallur, MD, Associate Chief Medical Officer	Discussion	**6:17 – 6:32**
9.	**REFRESH STEEEP DASHBOARD MEASURES FOR FY25**	Shreyas Mallur, MD, Associate Chief Medical Officer	Discussion	**6:32 – 6:47**
10.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**6:47 – 6:48**
11.	*Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff quality assurance committee* **QUALITY COUNCIL MINUTES** a. Quality Council Minutes (05/01/2024)	Carol Somersille, MD Quality Committee Chair	Information	**6:48– 6:49**
12.	*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* **RECOMMEND FOR APPROVAL CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer	Motion Required	**6:49 – 6:59**
13.	*Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff quality assurance committee* **VERBAL SERIOUS SAFETY/RED ALERT EVENT REPORT**	Shreyas Mallur, MD, Associate Chief Medical Officer	Discussion	**6:59 – 7:04**
14.	*Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management:* **EXECUTIVE SESSION**	Carol Somersille, MD Quality Committee Chair	Discussion	**7:04 – 7:09**
15.	**RECONVENE TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:09 – 7:10**
16.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:10 – 7:11**
17.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Discussion	**7:11 – 7:14**

AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
18. ADJOURNMENT	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:14 – 7:15**

Minutes of the Open Session of the Quality, Patient Care and Patient Experience Committee of the El Camino Health Board of Directors
Monday, May 6, 2024
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Carol Somersille, MD, Chair
Melora Simon, Vice Chair
Pancho Chang **
Philip Ho, MD (*at 5:43 pm*)
Prithvi Legha, MD
Jack Po, MD
Krutica Sharma, MD
John Zoglin

Members Absent

**via teleconference

Others Present
Dan Woods, CEO
Theresa Fuentes, CLO **
Cheryl Reinking, DPN, RN, CNO
Shreyas Mallur, Associate Chief Medical Officer
Lyn Garrett, Senior Director, Quality
Christine Cunningham, Chief Experience and Performance Improvement Officer
Deb Muro, CIO **
A.J. Reall, VP, Strategy
Ute Burness, ECHMN, VP, Quality & Payer Relations
Nicole Hartley, Executive Assistant II
Gabriel Fernandez, Coordinator, Governance Services

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Health (the "Committee") was called to order at **5:31 p.m.** by Chair Carol Somersille. A verbal roll call was taken. A quorum was present. Pancho Chang participated via teleconference. Dr. Phillip Ho arrived at 5:43 pm.	Call to order at **5:31 p.m.**
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	There were no AB-2449 requests by any members of the Quality Committee.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
4. PUBLIC COMMUNICATION	There were no comments from the public.	

5. CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. Consent Calendar Items (d) CDI Dashboard and (e) Core Measures were pulled for further discussion. A robust discussion regarding item (e) Core Measures ensued. The discussion included an evaluation of the methodology for how the goals are set and which national averages are utilized for comparative measures. **Motion**: To approve the consent calendar **Approval**: (a) Minutes of the Open Session of the Quality Committee Meeting (03/04/2024), (b) Minutes of the Closed Session of the Quality Committee Meeting (03/04/2024) **Received**: (c) FY24 Pacing Plan, (d) CDI Dashboard, and (e) Core Measures **Movant**: Po **Second**: Simon **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Consent Calendar Approved*** ***Action Items:*** *Staff to standardize and include visual indicators for all dashboards for review*
6. VERBAL CHAIR'S REPORT	Chair Somersille informed the committee that there were no reportable items for the Chair's report.	
7. PATIENT STORY	Ms. Reinking provided the Patient's Story. Highlighted in the story was a note from a patient's family who chose to write a letter to the hospital regarding an environmental services cleaning expert who made the patient's stay unforgettable. Ms. Reinking praised the exceptional efforts of the environmental services staff who come into contact with patients just as much as clinical staff and have just as much of a lasting impact on the overall quality of care that El Camino Health patients receive.	
8. EL CAMINO HEALTH MEDICAL NETWORK REPORT	Ms. Burness shared the El Camino Health Medical Network Report. Ms. Burness shared the CY24 Overall Performance vs the Targets for the year. The Committee inquired regarding the Core Quality Measures performance through Q1 and the ability to meet the targets set for the measures. The Committee requested that outpatient Medical Network Quality Council Minutes, similar to Inpatient Quality Council Minutes, be included in the packet. The Committee requested that the Governance Committee meet to discuss and provide guidance to the Quality Committee for this matter. Ms. Cunningham shared a report on Patient Experience for the El Camino Health Medical Network. Ms. Cunningham	

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	shared the details of the analysis completed and the methodology for assessing survey responses. The Committee expressed a desire to see increases in primary care metrics. Staff assured that the current projections still show favorable progress to achieve the FY2027 goals set by the organization.	
9. Q3 FY24 STEEEP DASHBOARD REVIEW / FY24 ENTERPRISE QUALITY DASHBOARD	The Committee discussed the Q3 FY24 STEEEP Dashboard and FY24 Enterprise Quality Dashboard. There was a robust discussion regarding Hospital readmissions and the multi-disciplinary rounds to decrease readmissions. Ms. Reinking discussed the processes and procedures to meet with leaders in both inpatient and outpatient settings and thoroughly examine and identify any gaps to prevent readmissions.	

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10. RECOMMEND FOR APPROVAL FY25 COMMITTEE PLANNING ITEMS	**Motion**: To recommend the FY25 Committee dates for approval **Movant**: Po **Second**: Simon **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None **Motion**: To recommend the FY25 Committee goals for approval **Movant**: Sharma **Second**: Simon **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None **Motion**: To recommend the FY25 pacing plan for approval **Movant**: Po **Second**: Sharma **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Recommendation for FY25 Committee Dates, Goals, and Pacing Plan Approved*** ***Actions**: For Committee Goals – Executive Sponsor to be listed as 'Chief Quality Officer.'* *Remove 'as facilitated by Director of Governance' from the review of annual committee self-assessment results.*
11. RECOMMEND FOR APPROVAL QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN	**Motion**: To recommend approval of the Quality Assessment and Performance Improvement Plan (QAPI) **Movant**: Simon **Second**: Po **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Recommendation for QAPI Approved***

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12. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session at 7:04 pm **Movant**: Sharma **Second**: Simon **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Recessed to Closed Session at 7:04 PM***
13. AGENDA ITEM 19: 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 7:56 PM***
14. AGENDA ITEM 20: RECOMMEND FOR APPROVAL FY25 ENTERPRISE QUALITY AND PATIENT EXPERIENCE GOAL	**Motion**: To recommend the FY 25 Proposed Organizational Performance Goals For Quality And Patient Experience With A Stretch Goal Changed To The 87th percentile for the LTR-Inpatient metric **Movant**: Sharma **Second**: Po **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma **Noes**: Zoglin **Abstain**: Simon **Absent**: None **Recused**: None	***Recommendation for FY25 Enterprise Quality and Patient Experience Goal Approved***
15. AGENDA ITEM 21: COMMITTEE ANNOUNCEMENTS	There were no additional announcements from the Committee.	
16. AGENDA ITEM 22: ADJOURNMENT	**Motion**: To adjourn at 7:59 p.m. **Movant**: Po **Second**: Simon **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Adjourned at 7:59 PM.***

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

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Gabriel Fernandez, Governance Services Coordinator

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

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FY24 COMMITTEE GOALS

Quality, Patient Care, and Patient Experience Committee

PURPOSE

The purpose of the Quality, Patient Care, and Patient Experience Committee ("Quality Committee" or the "Committee") is to advise and assist the El Camino Hospital Board of Directors ("Board") to monitor and support the quality and safety of care provided at El Camino Health ("ECH"). The Committee will utilize the Institute of Medicine's framework for measuring and improving quality care in these five domains: **s**afe, **t**imely, **e**ffective, **e**fficient, **e**quitable, and **p**erson-centered (STEEEP).

STAFF: **Shreyas Mallur, MD,** Associate Chief Medical Officer/ Interim Chief Quality Officer (Executive Sponsor)

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

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

Chair: Carol Somersille, MD
Executive Sponsor: Shreyas Mallur, MD, Associate Chief Medical Officer/ Interim Chief Quality Officer

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

To: Quality, Patient Care, and Patient Experience Committee
From: Shreyas Mallur, MD, Interim Chief Quality Officer
Date: June 3, 2024
Subject: Enterprise Quality, Safety, and Experience Dashboard through April 2024

Purpose:

To update the Quality, Patient Care, and Patient Experience Committee on quality, safety, and experience measure performance through April 2024 (unless otherwise noted).

Summary:

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

Background: A detailed memo supporting the measures on the STEEEP and Enterprise Quality, Safety and Experience dashboard provided in depth analysis of performance, process improvement initiatives and timelines for the recent May 6th, 2024, Quality Committee meeting. Many impacts of interventions do not change notably in three weeks' time (the time of the writing of this memo). This memo is not intended to be as comprehensive as the Quarterly combined STEEEP and Enterprise combined reports.

Assessment:

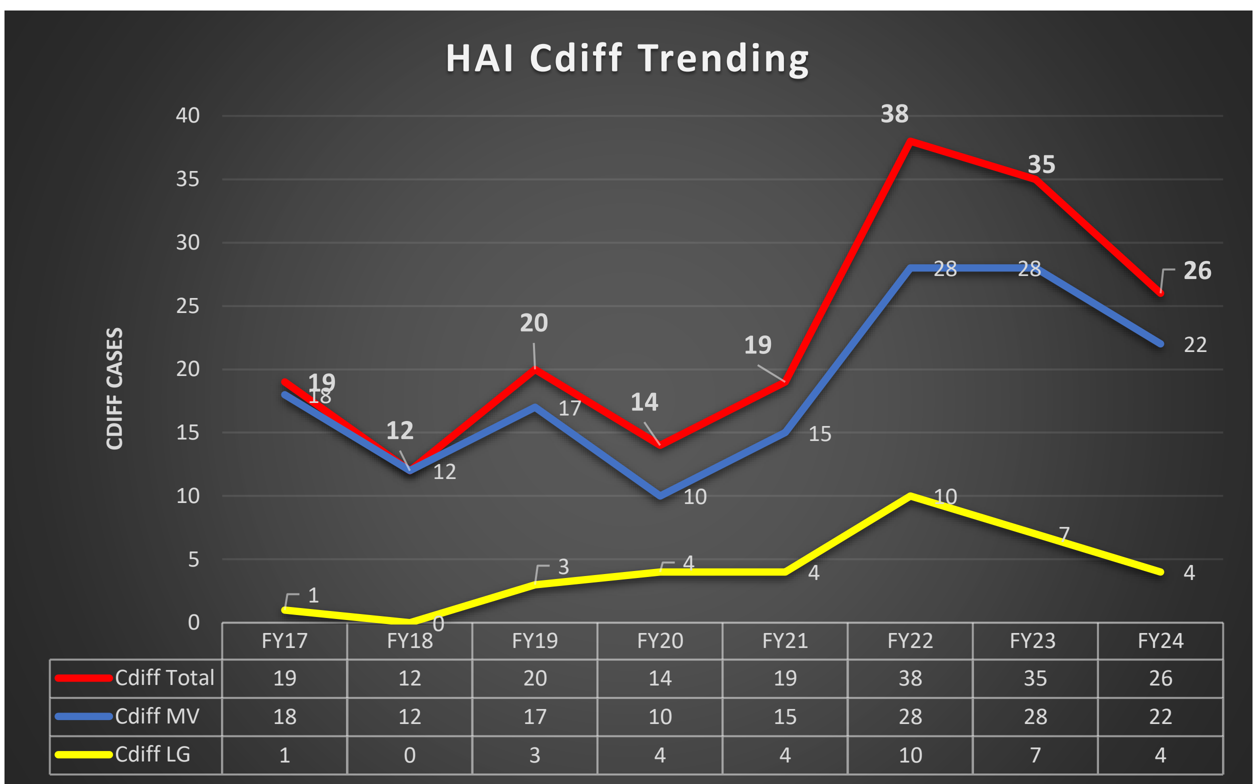
a) **Quality Measures**

i) **Hospital Acquired Condition Index 2.0** (lower is better). This metric is a composite of the weighted rates of 4 component measures. The table below illustrates the method and measures to formulate the HAC (Hospital Acquired Condition) Index.

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

The HAC Index 2.0 for the month of April is (0.5227) is favorable to target of 1.201. Year to date the performance of 1.097 is favorable to target.

(1) C. Difficile. We are laser sharp focused on reducing hospital onset C. Difficile infections. There was one case (favorable) in April 2024. There have been 26 total C. Diff infections YTD, our target for FY24 is to have <33 infections. We are on track to achieve our goal for FY 2024. The graph below shows ECH C. Diff trends going back to FY 2017.

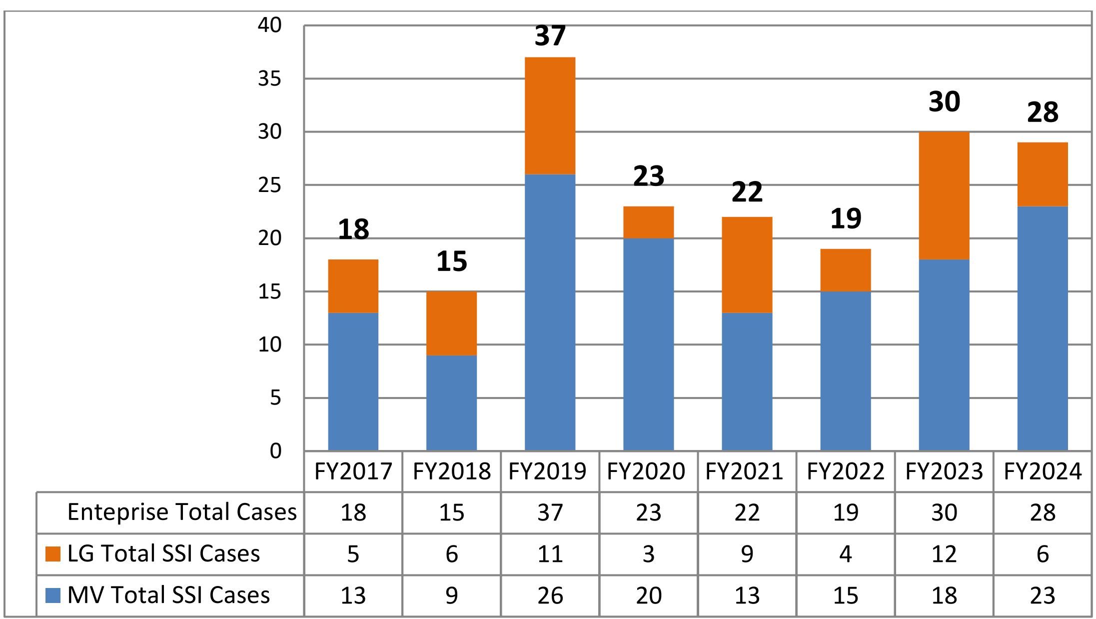


(2) Catheter Associated Urinary Tract Infection (CAUTI). There was one CAUTI in April 2024 (favorable). Year to date (1.10 cases/month) we are not yet favorable to target (1.05/month). We are very close to achieving our target for the year.

(3) Central Line Associated Blood Stream Infection (CLABSI). There were no CLABSI in April. There were 8 CLABSI in FY23, our target for FY24 is to have <= 7 infections. We are on track to achieve target with only 3 CLABSI year to date in FY24.

(4) There was one non-ventilator Hospital Acquired pneumonia infection in April. Improvement focus remains on consistent oral hygiene, getting patients up and out of bed, and reducing the risk of aspiration by having the head of the bed raised. We are not on track to achieve target for nvHAP reduction based on performance year-to-date. The quality manager and nurse champion supporting nvHAP reduction have increased the frequency and units for rounding and prioritizing nvHAP reduction efforts.

ii) Surgical Site Infections. There have been 28 surgical site infections in FY24. The goal for this fiscal year is to have less than 29 infections. There have been 5 hysterectomy surgical site infections year to date. None of these could have been prevented given the nature of the patients' disease burden and are unfortunately a known and expected complication of surgery to remove metastatic ovarian cancer. There have been three total knee replacement surgical site infections in FY24 compared to nine in FY23.



	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Enteprise Total Cases	18	15	37	23	22	19	30	28
LG Total SSI Cases	5	6	11	3	9	4	12	6
MV Total SSI Cases	13	9	26	20	13	15	18	23

iii) Readmission Index. The twelve-month rolling average continues to be stable. YTD, the readmission index is 1.13 which is (unfavorable) to target. We continue to focus on post discharge follow up appointment with a primary care provider, and close collaboration with our post-acute partners (Home health and Skilled Nursing Facilities). We are also working with our community partners and Santa Clara Valley Medical Center to facilitate appointments for our MediCal and Valley Healthcare patients.

iv) Sepsis and mortality risk adjusted indexes are stable and will improve when our inpatient hospice program gets up and running in the fourth quarter of FY24. Though our mortality index is (unfavorable) to target, we are improving year over year.

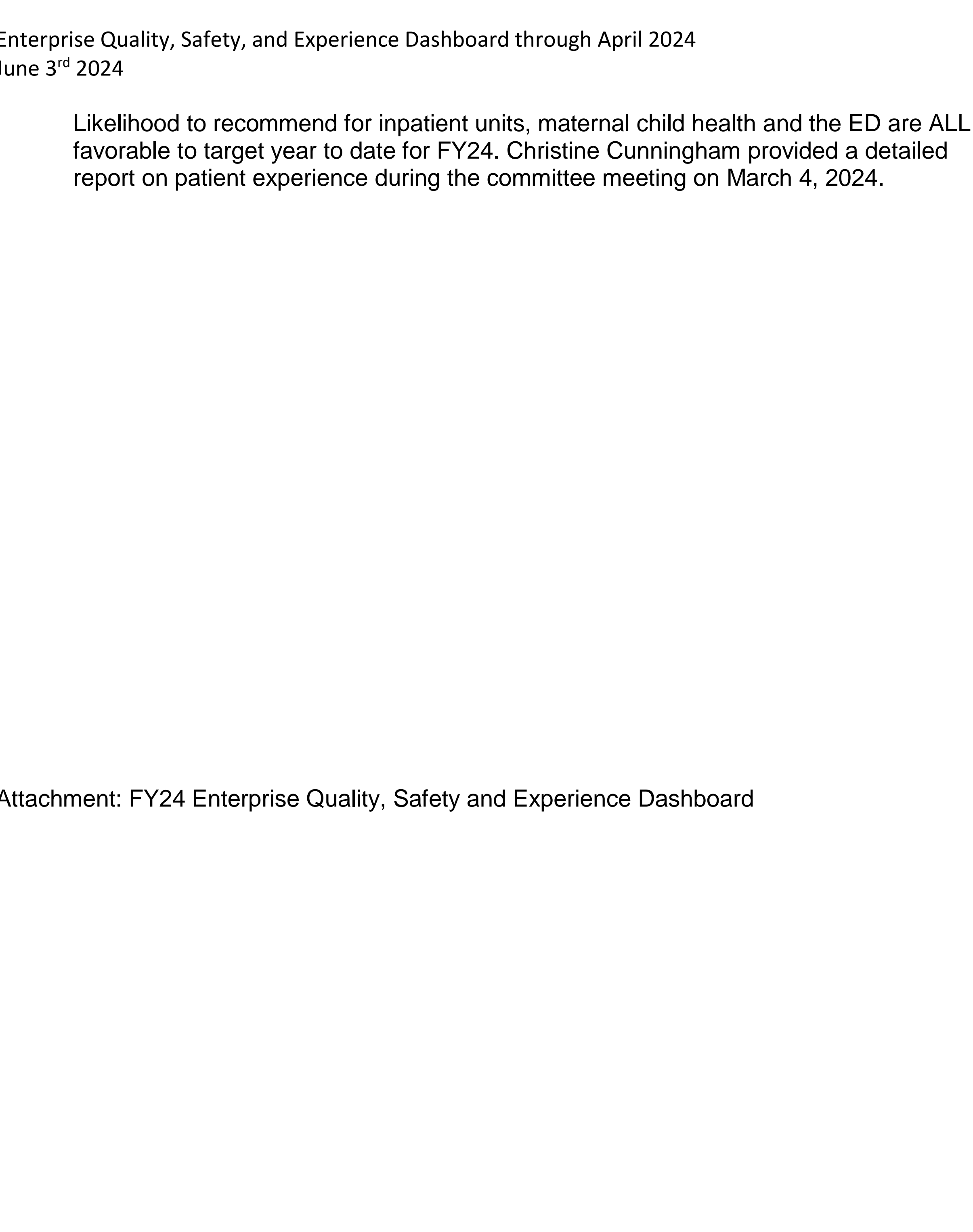
v) PC-02 Cesarean Birth. This has been stable for the past few quarters and is (unfavorable) to target. We have physician and RN taskforces working on this. We have seen a slight improvement year over year, and this continues to be a focus for us.

vi) PC-05 Exclusive Breast Milk Feeding continues to improve due to the focused efforts on providing culturally appropriate education and support to expectant and post-partum mothers during their prenatal visits, and during their post-partum hospital stay. The implementation of the breast milk bank shows a significant positive influence.

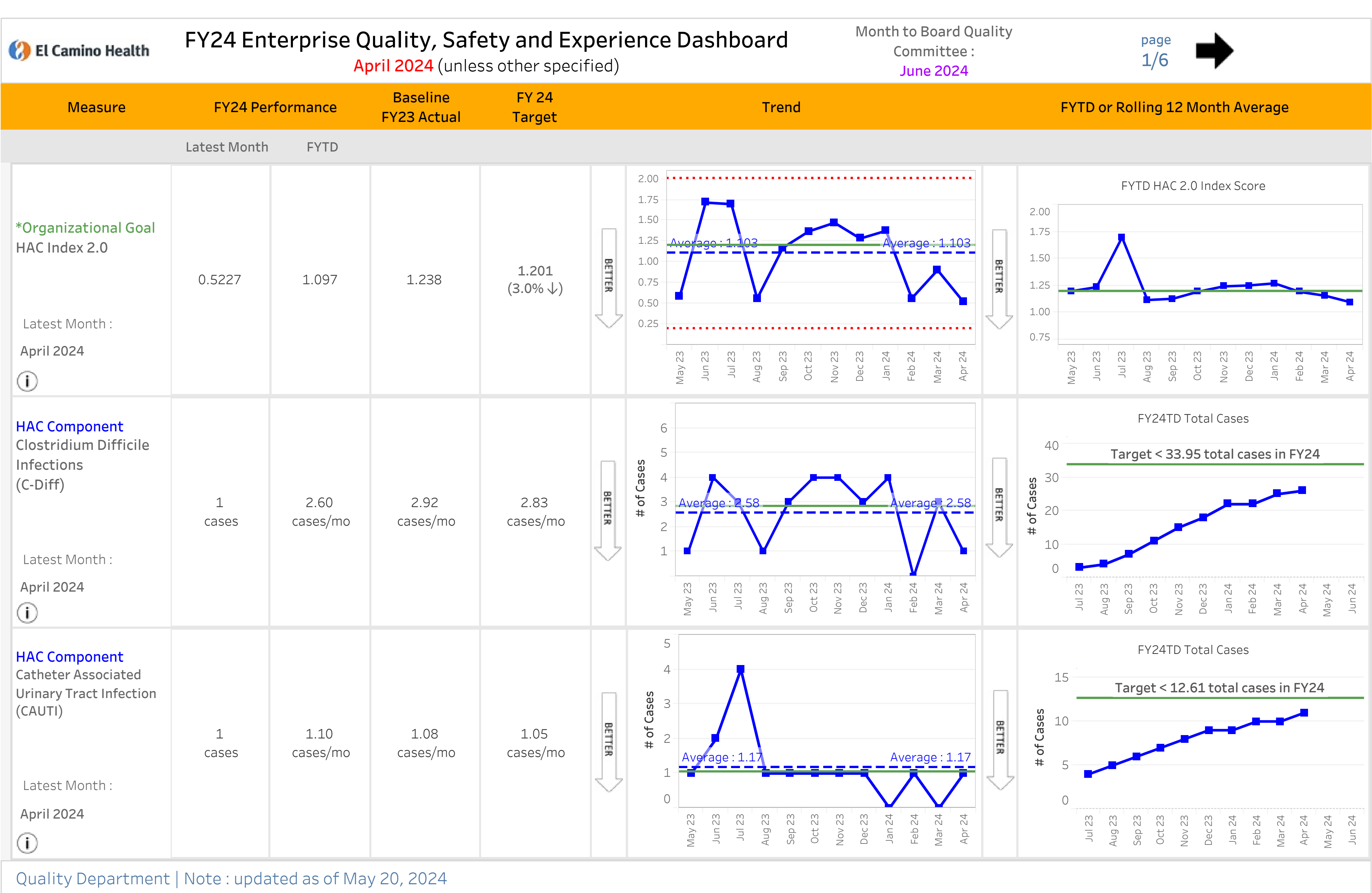
vii) Median time from ED (Emergency Department) Arrival to ED Departure performance continues to be outstanding. Considering the 10% increase in volumes on both campuses, the team’s ability to maintain favorable throughput performance is due to incessant focus on operational patient centered efficiency as described by CNO Cheryl Reinking in our previous committee meetings.

b) <u>Patient Experience Measures</u>

Likelihood to recommend for inpatient units, maternal child health and the ED are ALL favorable to target year to date for FY24. Christine Cunningham provided a detailed report on patient experience during the committee meeting on March 4, 2024.



Attachment: FY24 Enterprise Quality, Safety and Experience Dashboard



FY24 Enterprise Quality, Safety and Experience Dashboard

April 2024 (unless other specified)

Month to Board Quality Committee : June 2024

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Measure	FY24 Performance: Latest Month	FY24 Performance: FYTD	Baseline FY23 Actual	FY 24 Target
*Organizational Goal HAC Index 2.0 (Latest Month : April 2024)	0.5227	1.097	1.238	1.201 (3.0% ↓)
HAC Component Clostridium Difficile Infections (C-Diff) (Latest Month : April 2024)	1 cases	2.60 cases/mo	2.92 cases/mo	2.83 cases/mo
HAC Component Catheter Associated Urinary Tract Infection (CAUTI) (Latest Month : April 2024)	1 cases	1.10 cases/mo	1.08 cases/mo	1.05 cases/mo

Quality Department | Note : updated as of May 20, 2024

FY24 Enterprise Quality, Safety and Experience Dashboard

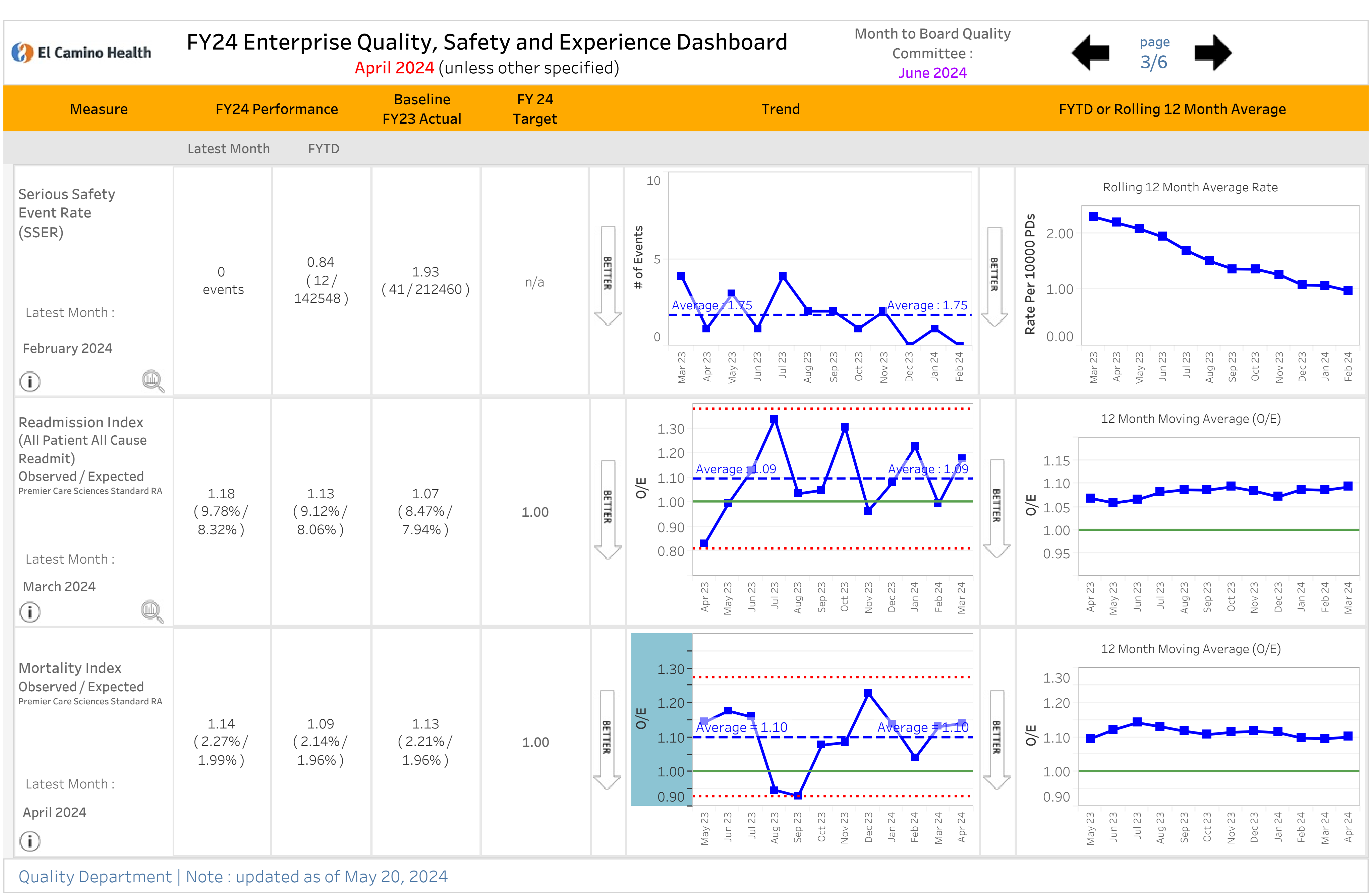
El Camino Health

April 2024 (unless other specified)

Month to Board Quality Committee : June 2024

Measure	FY24 Performance Latest Month	FY24 Performance FYTD	Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
HAC Component Central Line Associated Blood Stream Infection (CLABSI) Latest Month : April 2024	0 cases	0.30 cases/mo	0.67 cases/mo	0.65 cases/mo	Average : 0.23	FY24TD Total Cases; Target < 7.76 total cases in FY24
HAC Component non-ventilator Hospital-Acquired Pneumonia (nvHAP) Latest Month : April 2024	1 cases	2.20 cases/mo	2.00 cases/mo	1.94 cases/mo	Average : 2.17	FY24TD Total Cases; Target < 23.3 total cases in FY24
Surgical Site Infections (SSI) Latest Month : April 2024	0 cases	2.80 cases/mo	2.50 cases/mo	2.42 cases/mo	Average : 2.83	FY24TD Total Cases; Target < 27.16 total cases in FY24

Quality Department | Note : updated as of May 20, 2024



FY24 Enterprise Quality, Safety and Experience Dashboard

El Camino Health

April 2024 (unless other specified)

Month to Board Quality Committee : June 2024

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Measure	FY24 Performance Latest Month	FY24 Performance FYTD	Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
Serious Safety Event Rate (SSER) Latest Month : February 2024	0 events	0.84 (12 / 142548)	1.93 (41 / 212460)	n/a	# of Events; Average : 1.75	Rolling 12 Month Average Rate (Rate Per 10000 PDs)
Readmission Index (All Patient All Cause Readmit) Observed / Expected Premier Care Sciences Standard RA Latest Month : March 2024	1.18 (9.78% / 8.32%)	1.13 (9.12% / 8.06%)	1.07 (8.47% / 7.94%)	1.00	O/E; Average : 1.09	12 Month Moving Average (O/E)
Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : April 2024	1.14 (2.27% / 1.99%)	1.09 (2.14% / 1.96%)	1.13 (2.21% / 1.96%)	1.00	O/E; Average : 1.10	12 Month Moving Average (O/E)

Quality Department | Note : updated as of May 20, 2024

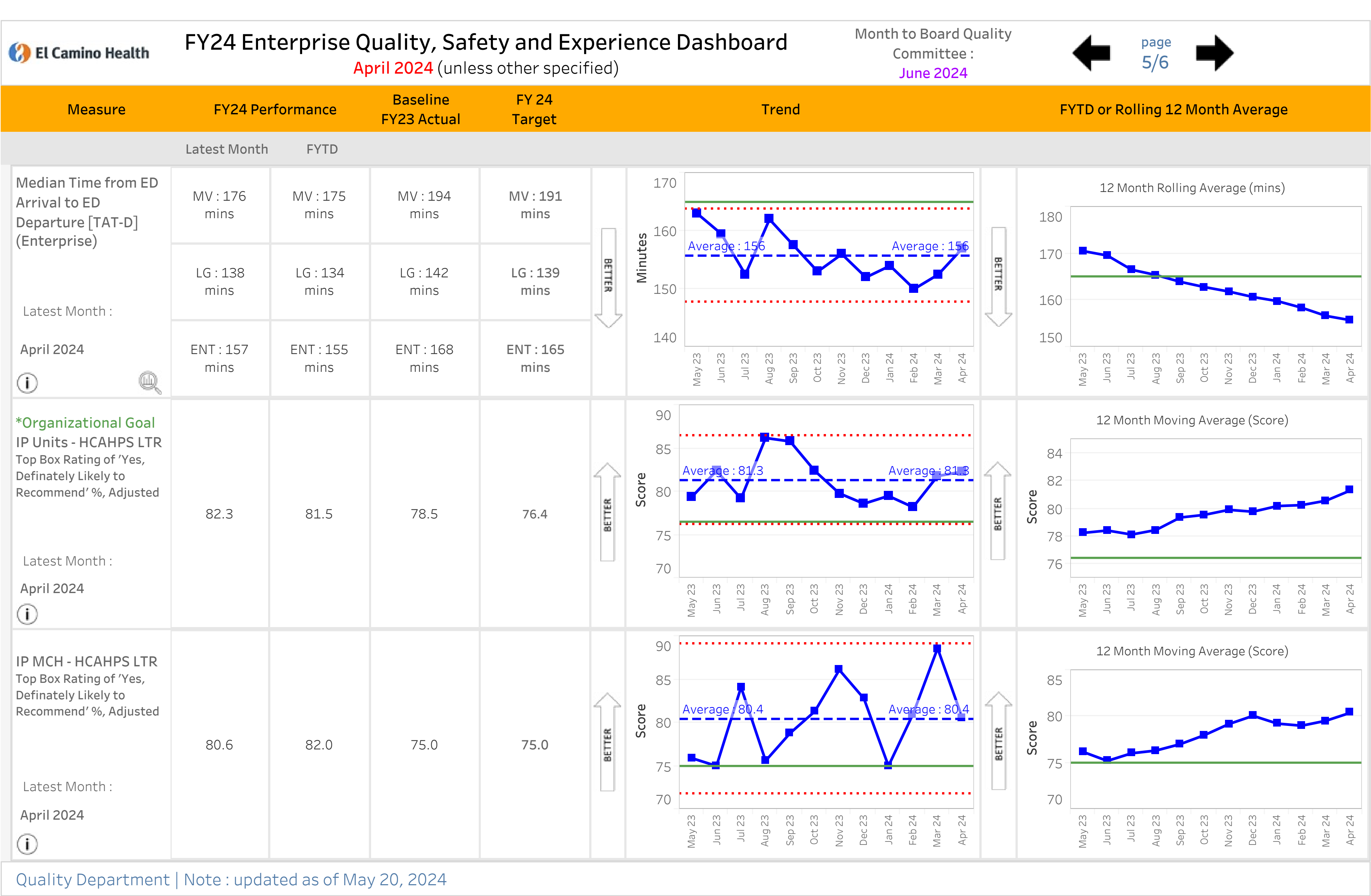
FY24 Enterprise Quality, Safety and Experience Dashboard

April 2024 (unless other specified)

Month to Board Quality Committee : June 2024

Measure	FY24 Performance: Latest Month	FY24 Performance: FYTD	Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
Sepsis Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : April 2024	0.97 (9.29% / 9.54%)	1.19 (13.46% / 11.33%)	1.21 (14.07% / 11.59%)	1.00	BETTER (lower) O/E: Average : 1.18 / Average : 1.18 May 23 – Apr 24	12 Month Moving Average (O/E) May 23 – Apr 24
PC-02 : Cesarean Birth Latest Month : February 2024	MV : 28.1% (38 / 135)	MV : 26.1% (336 / 1287)	MV : 27.6% (516 / 1869)	23.9% (FY24 ENT Target)	BETTER (lower) Average : 26.5% / Average : 26.5% Mar 23 – Feb 24	12 Month Rolling Average (Rate) Mar 23 – Feb 24
	LG : 19.0% (4 / 21)	LG : 19.3% (34 / 176)	LG : 19.4% (62 / 320)			
	ENT : 27.3% (38 / 139)	ENT : 25.3% (366 / 1446)	ENT : 26.4% (578 / 2189)			
PC-05 : Exclusive Breast Milk Feeding Latest Month : February 2024	MV : 70.0% (177 / 253)	MV : 68.8% (1619 / 2352)	MV : 58.1% (1966 / 3385)	65.1% (FY24 ENT & MV Target) 70.0% (FY24 LG Target)	BETTER (higher) Average : 64.4% / Average : 64.4% Mar 23 – Feb 24	12 Month Rolling Average (Rate) Mar 23 – Feb 24
	LG : 78.4% (40 / 51)	LG : 82.3% (289 / 351)	LG : 68.3% (427 / 625)			
	ENT : 60.4% (177 / 293)	ENT : 66.9% (1789 / 2673)	ENT : 59.7% (2393 / 4010)			

Quality Department | Note : updated as of May 20, 2024



El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

April 2024 (unless other specified)

Month to Board Quality Committee : June 2024

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Measure	FY24 Performance: Latest Month	FY24 Performance: FYTD	Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise) Latest Month : April 2024	MV : 176 mins	MV : 175 mins	MV : 194 mins	MV : 191 mins	BETTER (down)	BETTER (down)
	LG : 138 mins	LG : 134 mins	LG : 142 mins	LG : 139 mins		
	ENT : 157 mins	ENT : 155 mins	ENT : 168 mins	ENT : 165 mins		
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : April 2024	82.3	81.5	78.5	76.4	BETTER (up)	BETTER (up)
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : April 2024	80.6	82.0	75.0	75.0	BETTER (up)	BETTER (up)

Quality Department | Note : updated as of May 20, 2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

April 2024 (unless other specified)

Month to Board Quality Committee : June 2024

Measure	FY24 Performance: Latest Month	FY24 Performance: FYTD	Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : April 2024	74.3	75.4	71.7	71.7	BETTER ↑	BETTER ↑
*Organizational Goal ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : April 2024	83.8	82.1	82.7	81.3	BETTER ↑	BETTER ↑

Quality Department | Note : updated as of May 20, 2024

Measure	Definition Owner	Metric Definition	Data Source
*Organizational Goal HAC Index 2.0	H. Beeman, MD	For FY24, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (4) key inpatient safety events. The elements of the composite are weighted as noted: Clostridium difficile infections (C-Diff) 25%, Catheter Associated Urinary Tract Infection (CAUTI) 25%,Central Line Associated Blood Stream Infection (CLABSI) 25%, and non-ventilator hospital-acquired pneumonia (nvHAP) 25%,	See below
HAC Component Clostridium Difficile Infections (C-Diff)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
HAC Component Catheter Associated Urinary Tract Infection (CAUTI)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator**: Infection control Dept. **Denominator**: EPIC Report

Quality Department | Note : updated as of May 20, 2024

Measure	Definition Owner	Metric Definition	Data Source
HAC Component Central Line Associated Blood Stream Infection (CLABSI)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
HAC Component non-ventilator Hospital-Acquired Pneumonia (nvHAP)	C. Delogramatic	1) Internal metric: Inpatient non-ventilator hospital-acquired pneumonia cases. 2) Numerator inclusions: inpatients (18+yrs) w/ a specified pneumonia diagnosis code(s) with POA (present on admission) status of "N" (acquired during the hospital encounter), that is unrelated to mechanical ventilation; monthly, cases are reviewed & confirmed by the nvHAP workgroup. 3) Denominator EPSI patient days excluding 6070 NICU/Nursery Lvl 2, 6310/6315 MBU, 6340 Behavioral Health, 6440 IP Rehab, 6900 Pre-Op SSU, 7400 L&D, 7427 PACU 4) Latency: periodic; corrections may change previously reported results.	EPIC Clarity data warehouse; **Numerator** identified by nvHAP workgroup; **Denominator**: EPSi patient days nvHAP Tableau Dashboard maintained by: **Mohsina Shakir**
Surgical Site Infections (SSI)	C. Nalesnik	1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty". 4) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. 5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.	**Numerator:** Infection control Dept. **Denominator**: EPIC Report

Quality Department | Note : updated as of May 20, 2024

FY24 Enterprise Quality, Safety and Experience Dashboard

April 2024 (unless other specified)

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

Measure	Definition Owner	Metric Definition	Data Source
Serious Safety Event Rate (SSER)	S. Shah	1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. 2) Inclusions: events determined to be serious safety events per Safety Event Classification team 3) NOTE: the count of SSE HAPIs MAY differ from internally-tracked HAPIs 4) Denominator: EPSI Acute Adjusted Patient Days For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero. New classification rules in effect as of 7/1/22	HPI Systems Safety Event Tableau Dashboard maintained by: **Michael Moa**
Readmission Index (All Patient All Cause Readmit) Observed / Expected Premier Care Sciences Standard RA	H. Beeman, MD	1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause). 2) Based upon Premier's Care Sciences Standard Practice risk-adjustment + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient 4) NOTE: Excludes cases discharged from (1) hospital, then readmitted to the other hospital w/in 30D.	Premier Quality Advisor Readmission Tableau Dashboard maintained by: **Steven Sun**
Mortality Index Observed / Expected Premier Care Sciences Standard RA	H. Beeman, MD	1) Based upon Premier's Care Sciences Standard Practice RA for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient; exclusions: Patient Type = Rehab, Psychiatric or Hospice. For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= to zero.	Premier Quality Advisor

Quality Department | Note : updated as of May 20, 2024

Measure	Definition Owner	Metric Definition	Data Source
Sepsis Mortality Index Observed / Expected Premier Care Sciences Standard RA	J. Harkey, H. Beeman, MD	1) Numerator inclusions: Patient Type = Inpatient, Prin or 2nd diagnosis of sepsis & age 18+ yrs 2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB) For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Premier Quality Advisor
PC-02 : Cesarean Birth	H. Freeman	1) **Numerator**: Patients with cesarean births 2) **Denominator**: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	CMQCC
PC-05 : Exclusive Breast Milk Feeding	H. Freeman	1) **Numerator**: Newborns that were fed breast milk only since birth 2) **Denominator**: Single term newborns discharged alive from the hospital	CMQCC

Quality Department | Note : updated as of May 20, 2024

Measure	Definition Owner	Metric Definition	Data Source
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)	J. Baluom	ED Arrival to ED Departure (TAT-D - Direct Discharge): This metric is the median arrival to patient discharged time from ED. This metric excludes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery Patients who arrive via the ED. Time stamp is used for this calculation: ED Arrival - Patient Arrived in ED (50) (ADT_ARRIVAL_DTTM in Clarity "F_ED_ENCOUNTERS" table) ED Departure Time - "ED_Departure_DTTM" in Clarity "F_ED_ENCOUNTERS" table	EDSBAR Tableau Dashboard; EDOC Monthly Meeting Dashboard ED Tableau Dashboard maintained by: **Hsiao-Lan (Dee) Shih**
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. 2) Inclusions: Inpatient nursing units; excludes: MBU. 3) Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS

Quality Department | Note : updated as of May 20, 2024

Measure	Definition Owner	Metric Definition	Data Source
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted' For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey
*Organizational Goal ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	Switched Vendor NRC to PressGaney in January 2022. Started reporting in FY 23 dashboards 'Top Box, Received Date, and Unadjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey

Final Notes:
1.) SSER through February 2024
2.) Readmissions through March 2024
3.) PC-02 & PC-05 through February 2024
4.) Updated as of 2024-05-20

EL CAMINO HEALTH
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Lyn Garrett, MHA, MS, CPHQ, and Senior Quality Director
Date: June 3, 2024
Subject: Leapfrog Hospital Safety Grade Spring 2024

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on the Leapfrog Hospital Safety Grade (Spring 2024) for both Mountain View (MV) & Los Gatos (LG) Campuses.

Background:

Leapfrog started with a focus on employers looking at the safety of hospital care. In 2012 they decided to expand this work to reach out to consumers directly with a Hospital Safety Grade. This grade is meant to help patients determine how safe hospitals are for patients. The safety grade aims to provide patients with a letter grade rating that summarizes how likely they are to experience accidents, injuries, errors or harm while in the hospital. The two domains of the Leapfrog Hospital Safety Grade are:

1. Process/Structural Measures [12 measures] from the Leapfrog Hospital Survey and
2. Outcome Measures from CMS [10 measures]. Focusing on patient safety through participation in Leapfrog is supportive of our High Reliability aim of achieving zero patient harm.

Assessment:

Leapfrog Survey raises the bar for safer health care by building a movement for transparency. Over 2,000 hospitals voluntarily participate in the Leapfrog Program each year. The support and engagement of our leadership to participate in this survey shows our utmost pursuit for excellent and safe care. Leapfrog evaluates both campuses individually; however, for CMS specific metrics (HCAHPS and PSI-90), MV and LG share scores.

- **A.** Both Los Gatos and Mountain View Campus earned a letter grade A for the Spring 2024 reporting period.
- **B.** All the HCAHPS scores for the Leapfrog Spring of 2024 are above the Average Performing Hospital and are stable or improving for the timeframe 04/01/2022 - 03/31/2023.
- **C.** Both the Mountain View and Los Gatos campuses reported zero instances of foreign objects retained and air embolisms during the Leapfrog measurement period. Additionally, the Los Gatos campus achieved zero CAUTI cases in FY23. As a result of these exceptional clinical outcomes, both the Los Gatos and Mountain View campuses were awarded a Hospital Safety Grade of A.

MV Opportunities

A. The Mountain View campus performed on par with the national average for Catheter-Associated Urinary Tract Infections (CAUTI), Methicillin-Resistant Staphylococcus Aureus (MRSA), and C. difficile infections. CAUTI and CDIFF continue to be a focus in FY24 and will continue in FY25.

LG Opportunities

A. In FY2023, the Los Gatos campus performed below the national average for Central Line–Associated Bloodstream Infections (CLABSI) and C. difficile infections. We have seen a reduction in LG CLABSI from FY23 of 3 cases, to zero cases in FY24 year to date. A similar reduction in CDIFF from FY23 of 7 cases to 4 cases in FY24 year to date.

List of Attachments:

1. Attachment 1: MV Leapfrog Survey Spring 2024 letter grade calculator
2. Attachment 2: LG Leapfrog Survey Spring 2024 letter grade calculator

El Camino Hospital - Mountain View

© The Leapfrog Hospital Safety Grade Calculator -- April 2024

The Safety Grade Calculator is provided as a courtesy to help hospitals review their performance on each of the measures used in the Hospital Safety Grade as of the Data Snapshot Date (January 31, 2024).
Please enter your hospital's data and review this information to ensure that Leapfrog recorded the correct measure score from each publicly available data source.
More information about the Leapfrog Hospital Safety Grade and its methodology can be found at:
https://www.hospitalsafetygrade.org/for-hospitals/data-review/review-login

Means, standard deviations, and measure weights have been finalized following the Safety Grade Review Period as a result of changes that occurred during the review process (February 26, 2024 - March 15, 2024).

Instructions for the Hospital Safety Grade Calculator
1. Enter your hospital's source data in Column E (Your Hospital's Score)
2. If you have a score of zero (0), enter 0, not N/A, into the calculator
3. If you have a score that has been imputed or trimmed, enter only the numerical score into the calculator (do not include asterisks)
4. If you have a score of Not Available or Declined to Report for a measure, enter N/A into the calculator

Additional Information	
Final Safety Grade	The final calculated letter grade is found on the last row of the Hospital Safety Grade Calculator (row 33).
Reporting Periods	Please see the the third sheet in this file labeled "Reporting Periods" to view the reporting periods of each Safety Grade Measure.
Standard Weights	The standard weights will be applied unless you are scored as Not Available or Declined to Report for a measure. Please refer to column S to determine the final weight that was applied to each measure.
Negative z-scores	To ensure that a single measure does not dominate a hospital’s overall score in an unintended way, Leapfrog truncated negative z-scores at -5.00. Hospitals that have a calculated z-score below -5.00 on a measure will receive a modified z-score of -5.00 on that measure.

Note: If you have a score of:
-- zero (0), enter 0, in Column E.
-- Not Available or Declined to Report for a measure, enter N/A in Column E.

April 2024

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blanks)	Mean	Standard Deviation	Z-Score[1] Original Z-Score	Z-Score[1] Modified Z-Score	Inputs to Weighting Individual Measures[2] Evidence	Opportunity	Impact	Number of Component Measures[4]	Weight[3] Standard Weight	Final Weight (N/A redistributes)	Weighted Measure Score (Modified Z-Score x Final Weight)
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	91.81	14.36	0.5706	0.5706	2	1.16	3	1	5.569%	5.6%	0.0318
	Bar Code Medication Administration (BCMA)	100	93.42	10.47	0.6284	0.6284	2	1.11	3	1	5.433%	5.4%	0.0341
	ICU Physician Staffing (IPS)	100	63.29	44.05	0.8333	0.8333	2	1.70	3	1	7.217%	7.2%	0.0601
	Safe Practice 1: Culture of Leadership Structures and Systems	120.00	117.59	6.43	0.3743	0.3743	1	1.05	2	1	3.166%	3.2%	0.0119
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	120.00	117.08	11.32	0.2583	0.2583	1	1.10	2	1	3.252%	3.3%	0.0084
	Total Nursing Care Hours per Patient Day	100	74.69	30.66	0.8255	0.8255	2	1.41	2	1	4.909%	4.9%	0.0405
	Hand Hygiene	100	78.65	26.10	0.8180	0.8180	2	1.33	2	1	4.749%	4.7%	0.0388
	H-COMP-1: Nurse Communication	91	89.67	2.59	0.5128	0.5128	1	1.03	2	1	3.114%	3.1%	0.0160
	H-COMP-2: Doctor Communication	90	89.52	2.51	0.1908	0.1908	1	1.03	2	1	3.112%	3.1%	0.0059
	H-COMP-3: Staff Responsiveness	82	81.14	4.46	0.1923	0.1923	1	1.05	2	1	3.167%	3.2%	0.0061
	H-COMP-5: Communication about Medicines	74	74.09	4.15	-0.0222	-0.0222	1	1.06	2	1	3.169%	3.2%	-0.0007
	H-COMP-6: Discharge Information	88	84.90	3.78	0.8184	0.8184	1	1.04	2	1	3.145%	3.1%	0.0257
Outcome Measures	Foreign Object Retained	0.000	0.014	0.05	0.2801	0.2801	1	3.00	2	1	4.259%	4.3%	0.0119
	Air Embolism	0.000	0.001	0.01	0.0731	0.0731	1	3.00	1	1	2.434%	2.4%	0.0018
	Falls and Trauma	0.090	0.428	0.43	0.7929	0.7929	2	2.00	3	1	4.860%	4.9%	0.0385
	CLABSI	0.463	0.730	0.59	0.4505	0.4505	2	1.81	3	1	4.523%	4.5%	0.0204
	CAUTI	0.708	0.627	0.53	-0.1529	-0.1529	2	1.85	3	1	4.589%	4.6%	-0.0070
	SSI: Colon	0.790	0.845	0.68	0.0814	0.0814	2	1.80	2	1	3.413%	3.4%	0.0028
	MRSA	0.817	0.793	0.61	-0.0399	-0.0399	2	1.77	3	1	4.442%	4.4%	-0.0018
	C. Diff.	0.470	0.455	0.35	-0.0438	-0.0438	2	1.77	3	1	4.455%	4.5%	-0.0020
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	158.52	168.38	21.92	0.4499	0.4499	1	1.13	2	1	1.984%	2.0%	0.0089
	CMS Medicare PSI 90: Patient safety and adverse events composite	0.79	1.01	0.19	1.1614	1.1614	1	1.19	2	10	15.041%	15.0%	0.1747
Process Measure Domain Score:		0.2787											
Outcome Measure Domain Score:		0.2483											
Process/Outcome Domains - Combined Score:		0.5270											
Normalized Numerical Score:		3.5270											
Hospital Safety Grade (Letter Grade):		A											

Additional Resources:

[1]Please refer to the 'Calculating Z-scores' section of the methodology document for more details.
[2]Please refer to the 'Weighting Individual Measures' section of the methodology document for more details.
[3]Please refer to the 'Dealing with Missing Data' section of the methodology document for more details.
[4]Please refer to the 'Number of Component Measures' section of the methodology document for more details.

Spring 2024

Measure Domain	Measure	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	2023 Leapfrog Hospital Survey	2023	Imputation Model Applied[i]	N/A
	Bar Code Medication Administration (BCMA)	2023 Leapfrog Hospital Survey	2023	Imputation Model Applied[i]	N/A
	ICU Physician Staffing (IPS)	2023 Leapfrog Hospital Survey	2023	Imputation Model Applied[i]	N/A
	Safe Practice 1: Culture of Leadership Structures and Systems	2023 Leapfrog Hospital Survey	2023	N/A	N/A
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	2023 Leapfrog Hospital Survey	2023	N/A	N/A
	Total Nursing Care Hours per Patient Day	2023 Leapfrog Hospital Survey	2023	N/A	N/A
	Hand Hygiene	2023 Leapfrog Hospital Survey	2023	Imputation Model Applied[i]	N/A
	H-COMP-1: Nurse Communication	CMS	04/01/2022 - 03/31/2023	N/A	N/A
	H-COMP-2: Doctor Communication	CMS	04/01/2022 - 03/31/2023	N/A	N/A
	H-COMP-3: Staff Responsiveness	CMS	04/01/2022 - 03/31/2023	N/A	N/A
	H-COMP-5: Communication about Medicines	CMS	04/01/2022 - 03/31/2023	N/A	N/A
	H-COMP-6: Discharge Information	CMS	04/01/2022 - 03/31/2023	N/A	N/A
Outcome Measures	Foreign Object Retained	CMS	07/01/2020 - 06/30/2022	N/A	N/A
	Air Embolism	CMS	07/01/2020 - 06/30/2022	N/A	N/A
	Falls and Trauma	CMS	07/01/2020 - 06/30/2022	N/A	N/A
	CLABSI	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
	CAUTI	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
	SSI: Colon	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
	MRSA	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
	C. Diff.	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
	PSI 4: Death Rate among Surgical Inpatients with Serious Treatable Conditions	CMS	07/01/2020 - 06/30/2022	N/A	N/A
	CMS Medicare PSI 90: Patient safety and adverse events composite	CMS	07/01/2020 - 06/30/2022	N/A	N/A

[i]See the Instructions and Methodology document for more information about the Imputation Model used for missing CPOE, BCMA, Hand Hygiene, and IPS data.

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Negative z-scores	To ensure that a single measure does not dominate a hospital's overall score in an unintended way, Leapfrog truncated negative z-scores at -5.00. Hospitals that have a calculated z-score below -5.00 on a measure will receive a modified z-score of -5.00 on that measure.

El Camino Hospital - Los Gatos

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April 2024

Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blanks)	Mean	Standard Deviation	Z-Score[1]		Inputs to Weighting Individual Measures[2]				Weight[3]		Weighted Measure Score (Modified Z-Score x Final Weight)
					Original Z-Score	Modified Z-Score	Evidence	Opportunity	Impact	Number of Component Measures[4]	Standard Weight	Final Weight (N/A redistributes)	
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	91.81	14.36	0.5706	0.5706	2	1.16	3	1	5.569%	5.6%	0.0318
	Bar Code Medication Administration (BCMA)	100	93.42	10.47	0.6284	0.6284	2	1.11	3	1	5.433%	5.4%	0.0341
	ICU Physician Staffing (IPS)	5	63.29	44.05	-1.3234	-1.3234	2	1.70	3	1	7.217%	7.2%	-0.0955
	Safe Practice 1: Culture of Leadership Structures and Systems	120.00	117.59	6.43	0.3743	0.3743	1	1.05	2	1	3.166%	3.2%	0.0119
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	120.00	117.08	11.32	0.2583	0.2583	1	1.10	2	1	3.252%	3.3%	0.0084
	Total Nursing Care Hours per Patient Day	100	74.69	30.66	0.8255	0.8255	2	1.41	2	1	4.909%	4.9%	0.0405
	Hand Hygiene	100	78.65	26.10	0.8180	0.8180	2	1.33	2	1	4.749%	4.7%	0.0388
	H-COMP-1: Nurse Communication	91	89.67	2.59	0.5128	0.5128	1	1.03	2	1	3.114%	3.1%	0.0160
	H-COMP-2: Doctor Communication	90	89.52	2.51	0.1908	0.1908	1	1.03	2	1	3.112%	3.1%	0.0059
	H-COMP-3: Staff Responsiveness	82	81.14	4.46	0.1923	0.1923	1	1.05	2	1	3.167%	3.2%	0.0061
	H-COMP-5: Communication about Medicines	74	74.09	4.15	-0.0222	-0.0222	1	1.06	2	1	3.169%	3.2%	-0.0007
	H-COMP-6: Discharge Information	88	84.90	3.78	0.8184	0.8184	1	1.04	2	1	3.145%	3.1%	0.0257
Outcome Measures	Foreign Object Retained	0.000	0.014	0.05	0.2801	0.2801	1	3.00	2	1	4.259%	4.7%	0.0131
	Air Embolism	0.000	0.001	0.01	0.0731	0.0731	1	3.00	1	1	2.434%	2.7%	0.0020
	Falls and Trauma	0.090	0.428	0.43	0.7929	0.7929	2	2.00	3	1	4.860%	5.3%	0.0423
	CLABSI	1.354	0.730	0.59	-1.0551	-1.0551	2	1.81	3	1	4.523%	5.0%	-0.0524
	CAUTI	0.000	0.627	0.53	1.1804	1.1804	2	1.85	3	1	4.589%	5.0%	0.0594
	SSI: Colon	0.672	0.845	0.68	0.2549	0.2549	2	1.80	2	1	3.413%	3.7%	0.0095
	MRSA	N/A	0.793	0.61	N/A	N/A	2	1.77	3	1	4.442%	0.0%	0.0000
	C. Diff.	0.785	0.455	0.35	-0.9392	-0.9392	2	1.77	3	1	4.455%	4.9%	-0.0459
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	158.52	168.38	21.92	0.4499	0.4499	1	1.13	2	1	1.984%	2.2%	0.0098
	CMS Medicare PSI 90: Patient safety and adverse events composite	0.79	1.01	0.19	1.1614	1.1614	1	1.19	2	10	15.041%	16.5%	0.1917

Process Measure Domain Score:	0.1231
Outcome Measure Domain Score:	0.2296
Process/Outcome Domains - Combined Score:	0.3526
Normalized Numerical Score:	3.3526
Hospital Safety Grade (Letter Grade):	A

Additional Resources:

[1]Please refer to the 'Calculating Z-scores' section of the methodology document for more details.

[2]Please refer to the 'Weighting Individual Measures' section of the methodology document for more details.

[3]Please refer to the 'Dealing with Missing Data' section of the methodology document for more details.

[4]Please refer to the 'Number of Component Measures' section of the methodology document for more details.

Spring 2024

Measure Domain	Measure	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	2023 Leapfrog Hospital Survey	2023	Imputation Model Applied[i]	N/A
	Bar Code Medication Administration (BCMA)	2023 Leapfrog Hospital Survey	2023	Imputation Model Applied[i]	N/A
	ICU Physician Staffing (IPS)	2023 Leapfrog Hospital Survey	2023	Imputation Model Applied[i]	N/A
	Safe Practice 1: Culture of Leadership Structures and Systems	2023 Leapfrog Hospital Survey	2023	N/A	N/A
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	2023 Leapfrog Hospital Survey	2023	N/A	N/A
	Total Nursing Care Hours per Patient Day	2023 Leapfrog Hospital Survey	2023	N/A	N/A
	Hand Hygiene	2023 Leapfrog Hospital Survey	2023	Imputation Model Applied[i]	N/A
	H-COMP-1: Nurse Communication	CMS	04/01/2022 - 03/31/2023	N/A	N/A
	H-COMP-2: Doctor Communication	CMS	04/01/2022 - 03/31/2023	N/A	N/A
	H-COMP-3: Staff Responsiveness	CMS	04/01/2022 - 03/31/2023	N/A	N/A
	H-COMP-5: Communication about Medicines	CMS	04/01/2022 - 03/31/2023	N/A	N/A
	H-COMP-6: Discharge Information	CMS	04/01/2022 - 03/31/2023	N/A	N/A
Outcome Measures	Foreign Object Retained	CMS	07/01/2020 - 06/30/2022	N/A	N/A
	Air Embolism	CMS	07/01/2020 - 06/30/2022	N/A	N/A
	Falls and Trauma	CMS	07/01/2020 - 06/30/2022	N/A	N/A
	CLABSI	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
	CAUTI	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
	SSI: Colon	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
	MRSA	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
	C. Diff.	2023 Leapfrog Hospital Survey	07/01/2022 - 06/30/2023	CMS	04/01/2022 - 03/31/2023
	PSI 4: Death Rate among Surgical Inpatients with Serious Treatable Conditions	CMS	07/01/2020 - 06/30/2022	N/A	N/A
	CMS Medicare PSI 90: Patient safety and adverse events composite	CMS	07/01/2020 - 06/30/2022	N/A	N/A

[i]See the Instructions and Methodology document for more information about the Imputation Model used for missing CPOE, BCMA, Hand Hygiene, and IPS data.

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP, RN, NEA-BC, DipACLM
Date: June 3, 2024
Subject: Patient Experience feedback via discharge phone call

Purpose: To provide the Committee with written patient feedback from a patient receiving care from El Camino Health.

Summary:

1. Situation: These comments are from a patient after having received care from the medical unit at ECH Mountain View.

2. Authority: To provide insight into one patient's experience with the discharge experience related to miscommunication regarding discharge medications.

3. Background: This patient was discharging and waited to receive his discharge medications, but by the time the patient discharged (and missed lunch) the pharmacy was closed. It was a Sunday and the pharmacy closes earlier than other days of the week.

4. Assessment: There was a lack of communication amongst staff members regarding the outpatient pharmacy hours and medication readiness which caused a delay in the patient receiving discharge medications and also the patient missed lunch leaving a poor impression of the experience at the end of the patient stay. However, the patient was pleased with other experiences during the hospitalization.

5. Other Reviews: None

6. Outcomes: This feedback has been shared with the unit and pharmacy staff members regarding the importance of communicating the pharmacy hours and assuring medications are prepared and ready for pick up before the pharmacy closes. The pharmacy hours have been placed on the Get Well TV Network so patients are aware of the hours. The staff have been re-trained to communicate with the pharmacy on the timing of prescription readiness so the coordination of discharge activities is optimized.

List of Attachments:

1. See patient comments.

Suggested Committee Discussion Questions:

1. How many patients utilize the outpatient pharmacy for discharge medications?

2. How does ECH perform service recovery in cases such as this one?

Patient Story

Expectation setting in terms of you know what the steps to discharge was amazing. It was amazing doctor had everything figured out for us that was really good but the pharmacy was not able to fill up my prescriptions before 3 hours after discharge so we didn't know all of those details and we didn't know that it was during lunch time and in those 3 hours we would not be getting lunch. These are small things but overall it has been fabulous care and have nothing negative about it but just improving the process.

EL CAMINO HEALTH
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Shreyas Mallur, MD, MBA, Interim Chief Quality Officer
Date: June 3rd, 2024
Subject: SDOH-1 and SDOH-2 CMS Mandates

Summary:

1. Background: The SDOH-1 (Social Determinants of Health Screening) requirement mandates that healthcare providers systematically screen patients for social determinants affecting health, such as housing instability, food insecurity, and transportation barriers. The SDOH-2 (Social Needs Action Plan) requirement compels providers to develop and implement action plans to address identified social needs, integrating these into patient care plans. Both requirements aim to improve health outcomes by addressing non-medical factors impacting patient health. Compliance involves regular data collection, documentation, and reporting to CMS to demonstrate efforts and outcomes in mitigating social health determinants.

2. Assessment: El Camino Health successfully attested on all measures for the reporting period 01/01/2023 – 12/31/2023. The required elements of performance for SDOH-1 and SDOH-2 are:

    1. Engagement of the hospital or health system to participate in a Statewide and/or National Perinatal Improvement Collaboration Program aimed at improving maternal outcomes during inpatient labor, delivery and postpartum care, and has implemented patient safety practices or bundles related to maternal morbidity to address complications, including, but not limited to, hemorrhage, severe hypertension/preeclampsia or sepsis.

    2. Hospital Commitment to Health Equity (HCHE). It measures if the hospital has a strategic plan for advancing health equity, including identifying priority population who currently experiencing health disparities. Identifying health equity goals and discrete action steps to achieve these goals. Outlines specific resources which have been dedicated to achieving our equity goals. Describes the approach for engaging key stakeholders, such as community-based organizations.

    3. Collects demographic information (such as self-reported race, national origin, primary language, and ethnicity data) and/or social determinant of health information on the majority of our patients.

    4. Report on five categories of SDOH:

        - House Instability Screening

- Food Insecurity Screening
- Transportation Needs
- Utility Difficulties
- Interpersonal Safety

3. Recommendation: Please review and reflect on El Camino Health SDOH-1 and SDOH-2 submitted report and action plan attached to this memo.

List of attachments:

1. SDOH-1 and SDOH-2 mandates
2. El Camino Health SDOH-1 and SDOH-2 Action Plan

El Camino Health Board of Directors
Quality Committee Memo

To: Quality, Patient Care and Patient Experience Committee
From: Shreyas Mallur, MD, MBA, Interim Chief Quality Officer
Date: June 3rd, 2024
Subject: SDOH-1 and SDOH-2 submission report and action plan for CY 2024

The following rates have been reported for period 01/01/2023 – 12/31/2023:

1. **SDOH Screening Rate**: The number of patients admitted for an inpatient hospital stay who are 18 years or older or the date of admission and are screened for all of the following five HRSNs (health related social needs) – (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.

   821 / 15062 (5% of the adult medical and surgical patients)

2. **Food Insecurity**: The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HRSN, and who screen positive for food insecurity.

   4 / 821 (0.5% of screened patients)

3. **Housing Instability:** The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HRSN, and who screen positive for housing instability.

   9 / 821 (1% of screened patients)

4. **Transportation needs:** The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HRSN, and who screen positive for transportation needs.

   0 /821 (0% of screened patients)

5. **Utilities difficulties:** The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HRSN, and who screen positive for utility difficulties.

   7/821 (0.9% of screened patients)

6. **Interpersonal Safety:** The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HRSN, and who screen positive for interpersonal safety.

   5 / 821 (0.6% of screened patients)

Action plan for CY 2024

1. Create an integrated governance structure: An integrated approach to SDOH data collection is imperative to avoid duplicative efforts, ensure data validity but most importantly accommodate patient preferences.

2. Train users to collect SDOH data: First, establish the WHY? it`s important to document SDOHs with real life clinical examples so that clinicians can buy in to the change. Establish scripts and workflows that can be easily replicated and scalable. Finally, hold workshops to give staff the chance to train and practice.

3. Set quantifiable goals: Develop process metrics, like screening rates and resource recommendations rates. Also, quality indicators reflected through the SDOH framework (readmission and house instability, mortality and food insecurity etc.)

4. A follow through mechanism on addressing social needs: Collaborate with care coordination, community benefit, district population health departments to address identified disparities, ranging from adding resources to the navigation programs, coordination efforts with community-based organizations, other renovative ideas to coordinate the continuum of care for socially vulnerable patients.

5. Determine a data governance and exchange structure: review regulations and contracts to determine how to exchange data with our partners.

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

To: Quality, Patient Care and Patient Experience Committee
From: Shreyas Mallur, M.D
Date: June 3rd 2024
Subject: Proposed FY24 Measures to include on STEEEP Dashboard

Background:

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

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

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

Recommendation:

Based on the methodology and findings identified above we recommend the following updates to the FY25 STEEEP Dashboard are displayed on the attached document, FY25 STEEEP Dashboard Measure Proposal.

The Quality Committee will review the first FY25 STEEEP dashboard in August 2024 prior to sharing the report with the ECHB during their August 2024 meeting.

Attachment:

1. FY25 STEEEP Dashboard Measure Proposal

Bibliography

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

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

FY24 Quarterly Board Quality Dashboard (STEEEP)

Quality Domain	Metric		Past Performance				Baseline	Target	Current Performance			
			FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	FY 23	FY 24	FY24 Q1	FY24 Q2	FY24 Q3	FYTD
Safe Care	HAC Index 2.0 Score		1.358	1.451	1.238	0.861	1.238	**1.201**	1.130	1.367	0.966	**1.158**
	HAC Component: Cdiff Weighted (25%) Rate (per 10,000 Patient Days)		0.627	1.165	0.874	0.629	0.830	**0.805**	0.649	1.019	0.680	**0.784**
	HAC Component: CAUTI Weighted (25%) Rate (per 1,000 Urinary Catheter Days)		0.136	0.162	0.218	0.177	0.171	**0.166**	0.356	0.192	0.058	**0.202**
	HAC Component: CLABSI Weighted (25%) Rate (per 1,000 Central Line Days)		0.511	0.000	0.080	0.000	0.154	**0.150**	0.000	0.075	0.147	**0.077**
	HAC Component: nvHAP Weighted (25%) Rate (per 1000 Patient Days)		0.084	0.124	0.066	0.055	0.082	**0.080**	0.125	0.081	0.080	**0.095**
	SSI Rate (per 100 surgical procedures) *(not part of HAC Index)*		0.314	0.552	0.196	0.463	0.380	**0.369**	0.564	0.350	0.551	**0.484**
Timely	Lab STAT Troponin TAT for ED (received to verification)		93.8%	88.8%	70.9%	78.0%	82.7%	**90.0%**	84.2%	81.3%	88.7%	**84.8%**
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)		78.4%	78.3%	78.3%	77.0%	78.0%	**84.0%**	76.5%	76.9%	81.4%	**78.4%**
Effective	Risk Adjusted Readmissions Index		1.05	1.18	1.05	1.09	1.09	**1.00**	1.14	1.12	1.12* (Jan-Feb 24)	**1.13*** **(July-Feb 24)**
	Risk Adjusted Mortality Index		1.03	1.14	1.19	1.14	1.13	**1.00**	1.00	1.14	1.09	**1.08**
	Risk Adjusted Sepsis Mortality Index		1.02	1.37	1.26	1.15	1.20	**1.00**	1.07	1.33	1.17	**1.21**
	PC-02 NTSV C-Section		28.8%	24.7%	24.0%	30.2%	27.0%	**23.9%**	26.4%	22.7%	28.3%	**25.1%**
Efficient	Length of Stay O/E		1.19	1.16	1.22	1.19	1.19	**1.15**	1.19	1.19	1.24	**1.20**
	Median Time from ED Arrival to ED Departure (Enterprise)		174 min	167 min	168 min	164 min	168 min	**165 min**	157 min	154 min	152 min	**155 min**
Equitable	Homeless Discharge Clothing Documentation Compliance		----	----	----	----	----	**100.0%**	50.5% (176/348)	64.9% (257/396)	73.1% (242/331)	**62.8%** **(675/1075)**
	Quality Council Health Equity Item Included in PI efforts (% of depts)		----	----	----	----	----	**50.0%**	0.0% (0/6)	33.3% (4/12)	100.0% (11/11)	**51.7%** **(15/29)**
	Sepsis Bundle Compliance by Race	Asian	----	----	----	----	----	**----**	73.7% (28/38)	84.9% (28/33)	82.6%* (19/23) (Jan-Feb 24)	**79.8%*** **(75/94)** **(July-Feb)**
	Sepsis Bundle Compliance by Race	Hispanic	----	----	----	----	----	**----**	72.2% (13/18)	78.3% (18/23)	100.0%* (3/3) (Jan-Feb 24)	**77.3%*** **(34/44)** **(July-Feb)**
	Sepsis Bundle Compliance by Race	White	----	----	----	----	----	**----**	84.6% (88/104)	84.7% (72/85)	87.8%* (43/49) (Jan-Feb 24)	**85.3%*** **(203/238)** **(July-Feb)**
	Sepsis Bundle Compliance by Race	Others	----	----	----	----	----	**----**	66.6% (10/15)	72.7% (8/11)	33.3%* (2/6) (Jan-Feb 24)	**62.5%*** **(20/32)** **(July-Feb)**
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend		79.9	78.8	76.6	78.4	78.5	**76.4**	84.0	80.3	79.9	**81.4**
	ED - Likelihood to Recommend (PG)		70.3	72.3	73.8	70.4	71.7	**71.7**	77.9	74.5	74.3	**75.5**
	MCH - HCAHPS Likelihood to Recommend		72.3	72.1	83.7	74.0	75.0	**75.0**	79.7	83.7	83.2	**82.2**

Updated: 04/22/24

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**

Quality Domain	Metric	
Safe Care	HAC Index 2.0 Score	
	HAC Component: Cdiff Weighted (35%) Rate (per 10,000 Patient Days)	
	HAC Component: CAUTI Weighted (*15%*) Rate (per 1,000 Urinary Catheter Days)	
	HAC Component: CLABSI Weighted (15%) Rate (per 1,000 Central Line Days)	
	HAC Component: nvHAP Weighted (3*5%*) Rate (per 1000 Patient Days)	
	SSI Rate (per 100 surgical procedures) *(not part of HAC Index)*	
Timely	Lab STAT Troponin TAT for ED (received to verification)	
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)	
Effective	Risk Adjusted Readmissions Index	
	Risk Adjusted Mortality Index	
	Risk Adjusted Sepsis Mortality Index	
	PC-02 NTSV C-Section	
Efficient	Length of Stay O/E	
	Median Time from ED Arrival to ED Departure (Enterprise)	
Equitable	Homeless Discharge Clothing Documentation Compliance	
	Quality Council Health Equity Item Included in PI efforts (% of depts)	
	Sepsis Bundle Compliance by Race	Asian
	Sepsis Bundle Compliance by Race	Hispanic
	Sepsis Bundle Compliance by Race	White
	Sepsis Bundle Compliance by Race	Others
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	
	ED - Likelihood to Recommend (PG)	
	MCH - HCAHPS Likelihood to Recommend	

Metric Definition
For FY24, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (4) key inpatient safety events. The elements of the composite are weighted as noted: Clostridium difficile infections (C-Diff) 35%, Catheter Associated Urinary Tract Infection (CAUTI) 15%,Central Line Associated Blood Stream Infection (CLABSI) 15%, and non-ventilator hospital-acquired pneumonia (nvHAP) 35%.
1) Based on NHSN defined criteria: inclusions: Inpatients, Peri-Op, Behavioral Health; exclusions: Rehab, NICU, outpatients, ED patients 2) All positive C.diff Toxin/antigen lab tests that result on or after the patient's 4th day of hospitalization 3) Latency: C-Diff infections may be identified up to 30 days, thus previously reported results may change.
1) Based on NHSN defined criteria 2) Exclusions : ED & OP
1) Based on NHSN defined criteria 2) Exclusions : ED & OP
≥ 3 days hospitalization & Not receiving mechanical ventilation. Evidence of order or procedure code for chest X-ray or computerized tomography of the chest. Administration of selected antimicrobials (e-Table 3) not previously administered in past 2 days and continued for ≥3 days (changes in antibiotics permitted during the 3 day period so long as each new agent was not used in the preceding 2 days). More detailed and specific definition can be provided.
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.
A metric that assists with ED through-put and timely diagnosis of cardiac injury. The measurement begins with a time stamp of the specimen being received in the clinical laboratory and ends with a time stamp of the Troponin result being released to EPIC.
Imaging TAT Criteria : TAT from Exam END to Exam Finalized, Routine orders only. Qualified exam won't include the exams that Prelim or ED Wet Read exists. On Target as defined as ED - <= 45 min. Over Target is defined as ED > 45 min. ED encounters
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.
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.
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)
1) Numerator: Patients with cesarean births 2) Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation
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.
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
EMTALA - Homeless Discharge Navigator. Specifically for Clothing documented and compliance. Epic data source.
Departments that present a Health Equity (HE) -related item during Quality Council presentation / total departments presented
Sample of patients age >18 years, presenting in the Emergency Dept or In-patient unit with Severe Sepsis/Septic Shock (Suspected or known infection, 2+SIRS, 1 new organ dysfunction). Retrospective or concurrent chart reviews identified from one or more of the following: Emergency Room work up/differential, admitting diagnosis, Sepsis Alert, safety reporting system, EHR surveillance, iCare reporting, ICD-10 discharge code. Time of Presentation(TOP): time at which all criteria for severe sepsis are present, OR provider documentation of severe sepsis, whichever is earliest. Race is as defined of patient registration input, collected & documented in Epic.
1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. 2) Inclusions: Inpatient nursing units; excludes: MBU. 3) Data run criteria, 'Top Box, Received Date, and Adjusted'
ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted'
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted'

FY2024 Measures

Quality Domain	Metric	
Safe Care	~~HAC Index 2.0 Score~~	
	HAC Component: Cdiff Weighted (25%) Rate (per 10,000 Patient Days)	
	HAC Component: CAUTI Weighted (25%) Rate (per 1,000 Urinary Catheter Days)	
	HAC Component: CLABSI Weighted (25%) Rate (per 1,000 Central Line Days)	
	~~HAC Component: nvHAP Weighted (25%) Rate (per 1000 Patient Days)~~	
	SSI Rate (per 100 surgical procedures) *(not part of HAC Index)*	
Timely	~~Lab STAT Troponin TAT for ED (received to verification)~~	
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)	
Effective	Risk Adjusted Readmissions Index	
	Risk Adjusted Mortality Index	
	Risk Adjusted Sepsis Mortality Index	
	PC-02 NTSV C-Section	
Efficient	Length of Stay O/E	
	Median Time from ED Arrival to ED Departure (Enterprise)	
Equitable	~~Homeless Discharge Clothing Documentation Compliance~~	
	Quality Council Health Equity Item Included in PI efforts (% of depts)	
	Sepsis Bundle Compliance by Race	Asian
	Sepsis Bundle Compliance by Race	Hispanic
	Sepsis Bundle Compliance by Race	White
	Sepsis Bundle Compliance by Race	Others
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	
	ED - Likelihood to Recommend (PG)	
	MCH - HCAHPS Likelihood to Recommend	

Quality Domain
Safe Care
Timely
Effective
Efficient
Equitable
Patient-centered

FY2025 Measures Proposal

Metric
C-Diff (per 10,000 Patient Days)
CAUTI Rate (per 1,000 Urinary Catheter Days)
CLABSI Rate (per 1,000 Central Line Days)
SSI Rate (per 100 surgical procedures)
Hand Hygiene Audit Compliance (Leapfrog definition)
Imaging TAT: ED including Xray (target = % completed ≤ 45 min)
Sepsis 3 Hour Bundle Compliance (Sep-1)
Risk Adjusted Readmissions Index
Risk Adjusted Mortality Index
Risk Adjusted Sepsis Mortality Index
PC-02 NTSV C-Section
Length of Stay O/E
Median Time from ED Arrival to ED Departure (Enterprise)
Social Driver of Health Screening Rate
Language Line Utilization
IP Units Enterprise - HCAHPS Likelihood to Recommend
ED - Likelihood to Recommend (PG)
MCH - HCAHPS Likelihood to Recommend