El Camino Health

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

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

Dr. Steven Xanthopoulos will be participating remotely from 4 Shore Avenue, Saco, Maine 04072

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: 986 0722 3492 # No participant code. Just press #.**

To watch the meeting, please visit: 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.

A copy of the agenda for the Regular Board 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
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**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
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	**5:30 – 5:40**
	a. Approve Minutes of the Open Session of the Quality Committee Meeting (06/03/2024) b. Approve Minutes of the Closed Session of the Quality Committee Meeting (06/03/2024) c. FY25 Pacing Plan			
6.	**COMMITTEE EXPERTISE REPORT**	Pancho Chang, Quality Committee Member	Information	**5:40 – 5:50**
7.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Discussion	**5:50– 6:00**
8.	**Q4 FY24 STEEEP DASHBOARD REVIEW/ FY25 ENTERPRISE QUALITY DASHBOARD**	Shreyas Mallur, MD, Associate Chief Medical Officer	Discussion	**6:00 – 6:25**
9.	**EL CAMINO HEALTH MEDICAL NETWORK REPORT**	Shahab Dadjou, President, El Camino Health Medical Network	Discussion	**6:25 – 6:50**
10.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**6:50 – 6:51**
11.	*Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff quality assurance committee* **QUALITY COUNCIL MINUTES** a. Quality Council Minutes (06/05/2024)	Carol Somersille, MD Quality Committee Chair	Information	**6:51– 7:01**
12.	*Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff quality assurance committee* **Q4 QUARTERLY QUALITY AND SAFETY REVIEW OF REPORTABLE EVENTS**	Shreyas Mallur, MD, Associate Chief Medical Officer	Motion Required	**7:01 – 7:06**
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* **RECOMMEND FOR APPROVAL CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer	Motion Required	**7:06 – 7:16**
14.	*Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff quality assurance committee* **VERBAL SERIOUS SAFETY EVENT REPORT**	Shreyas Mallur, MD, Associate Chief Medical Officer	Discussion	**7:16 – 7:21**
15.	*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	**7:21 – 7:31**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
16.	**RECONVENE TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:31 – 7:32**
17.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:32 – 7:33**
18.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Discussion	**7:33 – 7:39**
19.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:39 – 7:40**

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Health Board of Directors
Monday, June 3, 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
Jack Po, MD
Krutica Sharma, MD
John Zoglin

Members Absent
Prithvi Legha, MD

Others Present
Dan Woods, CEO
Theresa Fuentes, CLO
Cheryl Reinking, DPN, RN, CNO
Shreyas Mallur, Associate Chief Medical Officer / Interim CQO
Tracey Lewis Taylor, COO
Gabriel Fernandez, Coordinator, Governance Services

**via teleconference

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Health (the "Committee") was called to order at **5:33 p.m.** by Chair Carol Somersille. A verbal roll call was taken. A quorum was present.	Call to order at **5:33 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) FY24 Enterprise Quality Dashboard and (e) Leapfrog were pulled for further discussion. A discussion regarding item (d) FY24 Enterprise Quality Dashboard ensued. The discussion included an evaluation of information provided on the mortality index specifically pertaining to moving certain patients to inpatient hospice and how this can affect the index. The discussion regarding item (d) Leapfrog entailed the hospital score for El Camino Los Gatos ICU physician staffing and multidisciplinary rounds. **Motion**: To approve the consent calendar **Approval**: (a) Minutes of the Open Session of the Quality Committee Meeting (05/06/2024), (b) Minutes of the Closed Session of the Quality Committee Meeting (05/06/2024) **Received**: (c) Progress against FY24 Committee Goals, (d) FY24 Enterprise Quality Dashboard, (e) Leapfrog **Movant**: Po **Second**: Sharma **Ayes**: Somersille, Chang, Ho, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Legha **Recused**: None	***Consent Calendar Approved***
6. COMMITTEE EXPERTISE REPORT	Committee Member Simon presented the committee expertise report on CalAIM. Ms. Simon shared the background of CalAIM, the growing awareness of the importance of social determinants (or drivers) of health (SDOH) and the benefits of health and social services integration as a strategy for improving health and well-being. Ms. Simon covered the complex nature of Medi-Cal coverage and how the fragmentation leads to a system in which patients seeking care struggle to obtain the resources needed.	
7. PATIENT STORY	Ms. Reinking provided the Patient's Story to provide insight into one patient's experience with the discharge experience related to miscommunication regarding discharge medications. Ms. Reinking shared the steps taken to ensure a seamless delivery of prescriptions to patients awaiting discharge medications.	

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8. HEALTH CARE EQUITY	Dr. Mallur shared that El Camino Health successfully attested on all Social Determinants of Health (SDOH) measures for the reporting period 01/01/2023 – 12/31/2023. Dr. Mallur outlined the reported rates on SDOH Screening, Food Insecurity, Housing Instability, Transportation, Utilities difficulties, and Interpersonal Safety. Dr. Mallur proceeded to outline the action plan for calendar year 2024 to address the five health-related social needs metrics. A committee member asked if the social determinants of health would be addressed in our outpatient settings and was told not yet.	
9. REFRESH STEEEP DASHBOARD MEASURES FOR FY25	The Committee discussed the FY25 STEEEP Dashboard. Dr. Mallur covered the changes to the Dashboard from the previous FY24 STEEEP Dashboard. Dr. Mallur provided the rationale for the proposed removal and addition of certain measures. A robust discussion of the changes to the Dashboard ensued including changes to measurements of Lab STAT Troponin, Homeless Discharge Documentation Compliance, and ED throughput.	
10. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session at 6:54 pm **Movant**: Sharma **Second**: Simon **Ayes**: Somersille, Chang, Ho, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Legha **Recused**: None	***Recessed to Closed Session at 6:54 PM***
11. AGENDA ITEM 16: 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 Committee members present.	***Reconvened Open Session at 7:13 PM***
12. AGENDA ITEM 17: COMMITTEE ANNOUNCEMENTS	Director Zoglin shared concerns regarding personal scheduling issues when attempting to schedule services as a patient. Dr. Ho shared that the June meeting would be his and Dr. Legha's last meeting on the committee since they had completed their terms as Chiefs of Staff. The Committee Chair thanked Dr. Ho and Dr. Legha for their service to El Camino Health.	
13. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 7:16 p.m. **Movant**: Po **Second**: Simon **Ayes**: Somersille, Chang, Ho, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Legha **Recused**: None	***Adjourned at 7:16 PM.***

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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: Theresa Fuentes. Chief Legal Officer; Tracy Fowler, Director of Governance Services

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El Camino Health

APPROVED BY QC 05/06/2024

Quality, Patient Care, and Patient Experience Committee
FY25 Pacing Plan

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
STANDING AGENDA ITEMS												
Consent Calendar[1]		✓	✓		✓	✓		✓	✓		✓	✓
Verbal Committee Member Expertise Sharing or Chair's Report		✓	✓		✓	✓		✓	✓		✓	✓
Patient Experience Story		✓	✓		✓	✓		✓	✓		✓	✓
Serious Safety/Red Alert Event (as needed)		✓	✓		✓	✓		✓	✓		✓	✓
Recommend Credentialing and Privileges Report		✓	✓		✓	✓		✓	✓		✓	✓
Quality Council Minutes		✓	✓		✓	✓		✓	✓		✓	✓
SPECIAL AGENDA ITEMS – OTHER REPORTS												
Quality & Safety Review of reportable events		✓			✓			✓			✓	
Quarterly Board Level Quality/ Experience Dashboard Review		✓			✓			✓			✓	
El Camino Health Medical Network Report		✓			✓			✓			✓	
Committee Self-Assessment Results Review												✓
Annual Patient Safety Report			✓									
Annual Culture of Safety Survey Report			✓									
Patient Experience Report			✓						✓			
Health Equity Report						✓						✓
Recommend Safety Report for the Environment of Care					✓							
PSI Report						✓						
Value-Based Purchasing Report									✓			
Recommend Quality Assessment & Performance Improvement Plan (QAPI)					✓							
Refresh Quality/Experience Dashboard measures for FY26												✓
Artificial Intelligence Report						✓						
COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR												
Propose Committee Goals									✓			
Recommend Committee Goals											✓	
Propose FY Committee Meeting dates									✓			
Recommend FY Committee Meeting dates											✓	
Propose Organization Goals									✓			
Recommend Organization Goals											✓	
Propose Pacing Plan									✓			
Recommend Pacing Plan											✓	
Review & Revise Charter									✓			
Recommend Charter											✓	

1: Includes Approval of Minutes (Open & Closed), Current FY Monthly Quality/Experience Dashboard, Progress Against FY Committee Goals (Quarterly), Current FY Pacing Plan (Quarterly), CDI Dashboard (November), Core Measures (Semi-Annual), Leapfrog (June)

Introducing High Reliability Practices to Patient Safety Advocates in Indonesia

Quality, Patient Care, and Patient Experience Committee

Pancho Chang,

Fulbright Specialist Center of Excellence for Patient Safety Universitas Airlangga Surabaya, Indonesia

August 5, 2024

Indonesia Health Care

- Indonesia spends 2.9% of GDP on healthcare, one of lowest rates worldwide
- WHO ranking: 92/191 countries
- 25/100,000 MD/population ratio
- 2560 hospitals, 1930 (60%) private
- Lack of access to care (rural areas, islands), poor maternal and child health, very little mental health/substance abuse care
- Despite universal coverage (2014), high out of pocket costs (patients pay about 1/3rd)
- Weak data collection system for health data/vital statistics
- Decentralized, under-resourced government = uneven, inconsistent monitoring/enforcement

Patient Safety in Indonesia

- Early-Stage Development: Adverse event reporting; global trigger tools; primitive electronic medical records
- Pluses - universal insurance coverage (2014), 3 tier care system, diversifying market (care systems, providers, payers), relative religious tolerance
- Minuses - provider shortages, excess service demand, care coverage gaps, underdeveloped health data, health policy, payment policy, compliance practices

Center of Excellence for Patient Safety

- School of Public Health
- Airlangga University
- Surabaya
- CoE (2023) 1/17 national CoEs under the Indonesia Department of Education
- 6 faculty, 20-25 doctoral students, 80+ master’s students.
- #2 University, Indonesia
- #2 largest city, Indonesia

Move from Tactics to Strategy

Current Institutional Tactics.

- Train public health graduate students to use Global Trigger Tools
- Recruit public health faculty into Patient Safety Research Center
- Collaborate with regional patient safety researchers (Japan, Australia, Thailand)

Strategy Recommendations

- Expand scope. Introduce reliability science and High Reliability Organizations with IHI principles and El Camino practices.
- Add partners. Recruit payer and policymaker advisers.
- Grow policy reach. Partner with national/state hospital associations, other Centers of Excellence

High Reliability Organizations

Pillars

- Leadership Commitment
- Culture of Safety
- Process Improvement

Principles

- Sensitivity to operations
- Preoccupation with failure
- Reluctance to simplify
- Commitment to resilience
- Deference to expertise

Introduction Themes

- The future is already here - it’s just unevenly distributed
- Build an organization, not a response
- Train business analysts and project managers, not compliance officers
- Find payer and policymaker allies
- Make new data science friends
- Position the Center to take an active role in data automation, electronic health records development

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP, RN, NEA-BC, DipACLM
Date: August 5, 2024
Subject: Voice of the Patient Feedback

Purpose: To provide the Committee with written patient feedback that is received by the hospital.

Summary:

1. Situation: This comment was received from a patient who had received care in the Los Gatos Orthopedic Unit.

2. Authority: To provide the committee with written feedback regarding a recent experience with El Camino Health.

3. Background: This patient was admitted from the ED. When arriving on the unit, the room was not prepared in the way the patient had expected and items had to be gathered quickly to prepare the room for the patient's needs for continued care. The care throughout the rest of the stay was appropriate.

4. Assessment: Upon review, it was determined that the items were not in the room which were necessary for continued care such as an oxygen regulator and a piece of furniture. At times staff borrow from other rooms and then the rooms where the items were taken are not replaced. A checklist is available for items that should be in every room.

5. Other Reviews: None

6. Outcomes: The staff were reminded to use the checklist for the required items and that "borrowing items from other rooms" leaves someone else to deal with the problem in other rooms. A system was set up so that an audit will be done to ensure that every room is prepared for the next patient using the checklist of required items for each room.

List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. How are checklists and standard work implemented at El Camino Health?

2. How is this information shared with staff and their input incorporated into improvement initiatives?

Press Ganey Patient Comment

I understand the floor was busy, but on admission my room was minimally ready. There was no oxygen tree in the room, (I was transported on oxygen), no bedside table. These all had to be brought after I was already in bed with the RRN who transported me. Throughout the 4 days everyone treated me so well, always checked in on me, offered if I needed anything even if they were not my assigned RN or CNA (I did not have a CNA most of the time). AS, CNA and RNs went out of there way whenever I made a little request like for some soup, extra linen, communication with the MD about something I was asking for. The RTs were all so kind and a pleasure to talk to + be cared for. I would like to specially mention the staff who helped me during my hospitalization.

El Camino Health

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

To: Quality, Patient Care, and Patient Experience Committee
From: Shreyas Mallur, M.D, Interim Chief Quality Officer and Lyn Garrett, MHA, MS, CPHQ
Date: August 5th 2024
Subject: Enterprise Quality, Safety and Experience and STEEEP Dashboards through June 2024

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety, and experience measure performance through June 2024 (unless otherwise noted). This memo will describe performance from both the STEEEP and Enterprise Quality Dashboards.

Summary:

Situation: The FY 24 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.

Assessment:

A. Safe Care

Hospital Acquired Condition Index 2.0

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

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

1. HAC Index 2.0 is the strategic quality and safety goal for FY24. For the month of June (0.6584) and Fiscal Year-To-Date (0.9851) we are favorable to target of (1.201).

   a. **C. Difficile Infection:** The C. Diff rate per patient days x 10,000 (0.300) for the fourth quarter and year to date (0.669) are favorable to target (0.805). There have been 28 hospital acquired infections in FY24. Areas of focus to decrease C.

Diff are twofold. First, hospital wide education on C. Diff screening, testing and prevention. Second, deployment of an enterprise-wide hand hygiene program have been implemented. (Timeline for improvement: we are currently meeting our targets and focused on maintaining)

b. **Catheter Associated Urinary Tract Infection (CAUTI):** The rate of catheter associated urinary tract infection per catheter days for Q4 (0.062) is significantly improved from Q1 (0.356) and is lower (better) than target (0.166). There have been eleven CAUTI year to date with a goal to have less than twelve for the fiscal year. There were four infections in July, and no more than one per month in August 2024 through June 2024. There were zero CAUTI's enterprise wide in January, March, May and June of 2024. 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 fourth quarter of FY24. (Timeline for improvement: we are currently meeting our targets and focused on maintaining)

c. **Central Line Associated Blood Stream Infection (CLABSI)**. The rate of CLABSI for the fourth quarter (0.000) and year to date (0.057) are favorable to target (0.150). There have been three CLABSIs year to date. This time in FY23 there were eight CLABSIs. Our focus, to sustain our favorable CLABSI performance, is on optimizing care and management of hemodyalsis catheters. In FY23 the majority of CLABSIs were related to hemodyalsis catheters. (Timeline for improvement: we are currently meeting our targets and focused on maintaining)

d. **Non-ventilator Hospital-Acquired Pneumonia (nvHAP).** The FY24 Q4 nvHAP rate (0.083) improved from Q1 (0.125). However, we did not meet the nvHAP target and ended the year at (0.092) and is above target of (0.080). Two key 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. We ended the year with 27 cases of nvHAP as against a target of 23 cases. The quality manager and team have increased rounding focused on oral care and in the moment education of staff and patients about the importance of preventing nvHAP. (Timeline for improvement: we will continue to monitor nvHAP and continue best practices to reduce the incidence. Our prediction is that we should see improvement in Q1/Q2 of FY 2025)

2. **Surgical Site Infection**. The rate of surgical site infections for FY24 Q4 (0.413) is unfavorable to target (0.369). FYTD rate of (0.475) is unfavorable to target. Process improvement has included staff education on hand hygiene, surgical attire, and sterile equipment processing. Initiatives launched the previous FY have resulted in a significant decrease of TKR infections. The OR departments are continuing their work on vendor behavior and reducing traffic and door opening during orthopedic joint replacement surgical procedures. We have noticed an increase in SSIs in abdominal hysterectomies and biliary procedures this FY. We have instituted a task force to identify any opportunities in processes to address this increase. (Timeline for

improvement: We anticipate that our SSI rate will go down by Q2/Q3 or FY 2025. This is a major focus for the organization and we will devote significant resources to understand and implement any changes needed)

B. Timely

1. **Lab STAT Troponin Turnaround Time for Emergency Department (received to verification).** [1]The goal is to have 90% of results back within (40 minutes). Performance in Q4 FY24 (92.4%) is favorable to target (90.0%) . This improvement was subsequent to our identifying an issue with the analyzer and correcting the issue. FYTD was (86.8%) unfavorable to target of 90%. (Timeline for improvement: We are focused on sustaining the improvements deployed. We are confident that the measures implemented which resulted in improvement in Q4 will continue to sustain)
2. **Imaging Turnaround Time: ED including X Ray (target + % completed <= 45 minutes).** Performance for Q4 (81.0%) and YTD (79.0%) are unfavorable to target (84%). FY 24 Q4 results are improved and closer to target than prior quarters. The 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 took effect February 13, 2024. (Timeline for improvement: We anticipate improvement in the Turnaround times by Q2 2025)

C. Effective

1. Risk Adjusted Readmission Index. Performance through May YTD (1.12) is unfavorable to target (1.0). El Camino Health remains committed to ensuring timely follow-up care for patients under SVMD primary care providers, after they are discharged from the hospital. We are also partnering with our colleagues at the County as well as Palo Alto Medical Foundation to get timely appointments for patients who are discharged from the hospital.

In addition, our Post-Acute Network Integrated Care team has also implemented a process to identify high-risk patients and coordinate their care with our Preferred Aligned Network (PAN) providers, including home health care services and skilled nursing facilities. The goal is to ensure timely follow-up appointments with patients' primary care providers after they are discharged from a PAN provider, thereby reducing the risk of readmissions back to the hospital.

Furthermore, we have introduced other initiatives to lower readmissions, including a philanthropy-sponsored program by the ECH Foundation. This program provides free Naltrexone (Vivitrol) Long-Acting Injectable (LAI), a drug that reduces patients' dependency on opioids and alcohol. This initiative targets substance-related readmissions and went live on April 10th. (Timeline for improvement: We anticipate more accurate, and lower Readmission Index when we transition to our new Clinical Data Base partner in Q1 of FY25. There will be a learning curve when we make the change to understand the documentation nuances needed to optimize the accuracy of the denominator "expected readmission")

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2. Risk Adjusted Mortality Index. Performance for FY24Q4 (1.23) and YTD (1.12) are unfavorable to target (1.00). Mortality index tracks, and for this time frame, is driven by sepsis mortality. (Timeline for improvement: We anticipate more accurate, and lower Mortality Index when we transition to our new Clinical Data Base partner in Q1 of FY25. There will be a learning curve when we make the change to understand the documentation nuances needed to optimize the accuracy of the denominator “expected mortality”)

3. Sepsis Mortality Index. Performance for FY24Q4 (1.25) and YTD (1.22) is unfavorable to target (1.0). Patients often arrive in the ED in Septic Shock. We are working to increase Social Work and/or Palliative Care support in the ED for goals of care discussions. Pursue hospice when appropriate for patients in the ED to go home, or if admitted then to a robust GIP program. A recent process change internally was that the sepsis coordinators provide concurrent sepsis bundle compliance to ED physicians and staff in the real time. 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. (Timeline for improvement: The GIP program is planned for go-Live in Q1 of FY25. With a robust program, there will be a trickle-down impact on driving earlier referral for Palliative Care consultation. This alone, Palliative care consult” increases the expected risk of mortality 6-fold)

4. PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV. FY24Q4 performance through April of 2024 (29.5%) is unfavorable to target of 23.9%. Contributing factors to the increase is the patient population in this quarter which had a greater number of patients of advanced maternal age, and with medical co-morbidities which increases their risk of C-section. The MCH team shares data quarterly with the medical staff regarding individual physician NTSV rates. The introduction of a NTSV check list had a positive impact on decreasing c/s rate initially after roll out in Q2. What has been most impactful is the bi-weekly review by a multidisciplinary team of nurses, midwives, and physicians to review the indication for every single NTSV. When an opportunity for improvement is identified, MCH leaders reach out to the provider with feedback. (Timeline for improvement: We will not achieve target for YTD based on the Q1 and Q3 rates. Goal for improvement is to achieve target in the fourth quarter of FY24)

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, 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 (1.18) 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 are optimizing care coordination within our system to decrease length of stay. Here are specific interventions in place:
   - Within Epic a centralized care plan was created that pulls together important information about the patients care plan. This tool increased efficiency and allows the care team to obtain pertinent information in a timely way. Additionally, interdisciplinary team members can track internal and external delays which will offer insight into the primary reasons for delays in patient throughput.

- Since the initiation of Multidisciplinary rounds (MDR) in December 2023, there have been significant improvements in LOS within the pilot program for patients who stay in nursing unit 2C. The data indicates a noteworthy decrease of -1.1 days in LOS (as of 04/24/2024) for these patients. Given the successful demonstration, the MDR process was expanded to the nursing unit on 3C. In addition, the plan is to roll out the MDR process to 3 additional units in Q1 2025.
- 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. (Timeline for improvement: We anticipate improvement due to the changes implemented by Q3 of 2025)

2. **Median Time from ED Arrival to ED Departure (Enterprise).** The current FY24Q4 performance (155 minutes) and YTD (155 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 Q4 of FY24, documentation indicating that weather-appropriate clothing was provided to homeless patients prior to discharge improved from 64.9% to 81% (FYTD 66.2%). The Health Equity Department is collaborating with Patient Access Services, Clinical Documentation, the HIM Department, and the ED nursing clinical team. This partnership aims to enhance the accurate identification of our homeless population and address inefficiencies in our EMR system, which currently hinder consistent documentation of adherence to 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 fourth quarter of FY2024 six of six departments (100%) reported on a health equity measure during their annual performance improvement report at the monthly Quality Council meeting. This measure aligns with Join Commission and CMS requirements to engage leadership and clinical management staff in health equity initiatives.

3. Sepsis Bundle Compliance by Race. We continue to track and learn from the practice of segregating some of our quality measures by race, while simultaneously enhancing the accuracy of the race data we collect from our patients at registration. The reliability of the 'race' data provided by our patients needs to be improved before we can extract meaningful insights about sepsis bundle compliance across different racial groups. In collaboration, the Health Equity Department and the Quality Data Management Department have developed a race and ethnicity algorithm that enables accurate and consistent segregation of clinical outcomes based on these critical demographic data. Furthermore, in partnership with the Sepsis Quality Team, we have established the first-of-its-kind Health Equity Sepsis Bundle Compliance Dashboard. This tool allows us to

accurately identify gaps and plan for initiating process improvement project in specific groups.

F. Patient Centered

1. Inpatient HCAHPS Likelihood to Recommend. For the month of June (83.4) and FY24YTD (81.9) performance has exceeded the target of 76.4. This holds true for both the LG and MV campuses. We continue to rank in the top decile in the Bay Area. These increases were due to strong scores in our Key Drivers, that is Nurse Communication and Staff Worked Together (teamwork). We are continuing to upgrade our RN call system on both campuses leading to better responsiveness. We are on track to exceed this target for FY24.

2. Inpatient Maternal Child Health-HCAHPS Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend". For Q4 (81.4) and FY24YTD (82.) performance exceeded target of .75. We continue to perform in the top decile in the Bay Area and 87% nationally. Our new facility in Mountain View has rave reviews from our patients and families.

3. ED Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend". The overall ED top box score exceeded target (71.7) Q4 FY24 (75.6) and exceeding target (71.7) for fiscal year to date.

4. El Camino Health Medical Network: Likelihood to Recommend Care Provider Top Box Rating of "Yes, Definitely likely to Recommend". Our ECHMN Clinics exceeded target for the month of June (84.3) and YTD (81.3). We continue to work with our primary care clinics on access and scheduling (the organization is recruiting as fast as they can!).

Attachments:

1. Enterprise Quality Dashboard through March 2024
2. STEEEP Dashboard through Q3 of FY2024

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FY24 Quarterly Board Quality Dashboard (STEEEP)

Quality Domain	Metric		Past Performance FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	Baseline FY 23	Target FY 24	Current Performance FY24 Q1	FY24 Q2	FY24 Q3	FY24 Q4	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	0.444	**0.985**
Safe Care	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	0.300	**0.669**
Safe Care	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	0.062	**0.167**
Safe Care	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	0.000	**0.057**
Safe Care	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	0.083	**0.092**
Safe Care	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	0.578	0.413	**0.475**
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%	92.4%	**86.8%**
Timely	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%	81.0%	**79.1%**
Effective	Risk Adjusted Readmissions Index		1.05	1.18	1.05	1.09	1.07	**1.00**	1.14	1.12	1.14	1.08* (Apr-May 24)	**1.12* (July-May 24)**
Effective	Risk Adjusted Mortality Index		1.03	1.14	1.19	1.14	1.13	**1.00**	1.00	1.14	1.10	1.23	**1.12**
Effective	Risk Adjusted Sepsis Mortality Index		1.02	1.37	1.26	1.15	1.21	**1.00**	1.07	1.33	1.22	1.25	**1.22**
Effective	PC-02 NTSV C-Section		28.8%	24.7%	24.0%	30.2%	26.4%	**23.9%**	26.4%	22.7%	23.0%	29.5%* (Apr 24)	**24.6%* (July-Apr 24)**
Efficient	Length of Stay O/E		1.19	1.16	1.22	1.19	1.19	**1.15**	1.19	1.20	1.17	1.18	**1.20**
Efficient	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	**155 min**
Equitable	Homeless Discharge Clothing Documentation Compliance		----	----	----	----	----	**100.0%**	50.5% (176/348)	64.9% (257/396)	73.1% (242/331)	81.0%* (200/247) (Apr-May 24)	**66.2%* (875/1322) (July-May 24)**
Equitable	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)	100.0% (6/6)	**60.0% (21/35)**
Equitable	Sepsis Bundle Compliance by Race	Asian	----	----	----	----	----	**----**	73.7% (28/38)	84.9% (28/33)	82.6%* (19/23) (Jan-Feb 24)	N/A	**79.8%* (75/94) (July-Feb)**
Equitable	Sepsis Bundle Compliance by Race	Hispanic	----	----	----	----	----	**----**	72.2% (13/18)	78.3% (18/23)	100.0%* (3/3) (Jan-Feb 24)	N/A	**77.3%* (34/44) (July-Feb)**
Equitable	Sepsis Bundle Compliance by Race	White	----	----	----	----	----	**----**	84.6% (88/104)	84.7% (72/85)	87.8%* (43/49) (Jan-Feb 24)	N/A	**85.3%* (203/238) (July-Feb)**
Equitable	Sepsis Bundle Compliance by Race	Others	----	----	----	----	----	**----**	66.6% (10/15)	72.7% (8/11)	33.3%* (2/6) (Jan-Feb 24)	N/A	**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	83.4	**81.9**
Patient-centered	ED - Likelihood to Recommend (PG)		70.3	72.3	73.8	70.4	71.7	**71.7**	77.9	74.5	74.3	75.6	**75.5**
Patient-centered	MCH - HCAHPS Likelihood to Recommend		72.3	72.1	83.7	74.0	75.0	**75.0**	79.7	83.7	83.2	81.4	**82.0**

Updated: 07/16/24

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**

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Quality Domain	Metric		Metric Definition
Safe Care	HAC Index 2.0 Score		For FY24, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (4) key inpatient safety events. The elements of the composite are weighted as noted: Clostridium difficile infections (C-Diff) 35%, Catheter Associated Urinary Tract Infection (CAUTI) 15%,Central Line Associated Blood Stream Infection (CLABSI) 15%, and non-ventilator hospital-acquired pneumonia (nvHAP) 35%.
	HAC Component: Cdiff Weighted (35%) Rate (per 10,000 Patient Days)		1) Based on NHSN defined criteria: inclusions: Inpatients, Peri-Op, Behavioral Health; exclusions: Rehab, NICU, outpatients, ED patients 2) All positive C.diff Toxin/antigen lab tests that result on or after the patient's 4th day of hospitalization 3) Latency: C-Diff infections may be identified up to 30 days, thus previously reported results may change.
	HAC Component: CAUTI Weighted (*15%*) Rate (per 1,000 Urinary Catheter Days)		1) Based on NHSN defined criteria 2) Exclusions : ED & OP
	HAC Component: CLABSI Weighted (15%) Rate (per 1,000 Central Line Days)		1) Based on NHSN defined criteria 2) Exclusions : ED & OP
	HAC Component: nvHAP Weighted (35%) Rate (per 1000 Patient Days)		≥ 3 days hospitalization & Not receiving mechanical ventilation. Evidence of order or procedure code for chest X-ray or computerized tomography of the chest. Administration of selected antimicrobials (e-Table 3) not previously administered in past 2 days and continued for ≥3 days (changes in antibiotics permitted during the 3 day period so long as each new agent was not used in the preceding 2 days). More detailed and specific definition can be provided.
	SSI Rate (per 100 surgical procedures) *(not part of HAC Index)*		1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty". 4) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. 5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.
Timely	Lab STAT Troponin TAT for ED (received to verification)		A metric that assists with ED through-put and timely diagnosis of cardiac injury. The measurement begins with a time stamp of the specimen being received in the clinical laboratory and ends with a time stamp of the Troponin result being released to EPIC.
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)		Imaging TAT Criteria : TAT from Exam END to Exam Finalized, Routine orders only. Qualified exam won't include the exams that Prelim or ED Wet Read exists. On Target as defined as ED - <= 45 min. Over Target is defined as ED > 45 min. ED encounters
Effective	Risk Adjusted Readmissions Index		1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause). 2) Based upon Premier's Care Sciences Standard Practice risk-adjustment + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient 4) NOTE: Excludes cases discharged from (1) hospital, then readmitted to the other hospital w/in 30D.
	Risk Adjusted Mortality Index		1) Based upon Premier's Care Sciences Standard Practice RA for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient; exclusions: Patient Type = Rehab, Psychiatric or Hospice.
	Risk Adjusted Sepsis Mortality Index		1) Numerator inclusions: Patient Type = Inpatient, Prin or 2nd diagnosis of sepsis & age 18+ yrs 2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB)
	PC-02 NTSV C-Section		1) Numerator: Patients with cesarean births 2) Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation
Efficient	Length of Stay O/E		1) Based upon Premier's Care Sciences Standard Practice RA for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient; exclusions: Patient Type = Rehab, Psychiatric or Hospice.
	Median Time from ED Arrival to ED Departure (Enterprise)		ED Arrival to ED Departure (TAT-D - Direct Discharge): This metric is the median arrival to patient discharged time from ED. This metric excludes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery Patients who arrive via the ED. Time stamp is used for this calculation: ED Arrival - Patient Arrived in ED (50) (ADT_ARRIVAL_DTTM in Clarity "F_ED_ENCOUNTERS" table) ED Departure Time - "ED_Departure_DTTM" in Clarity "F_ED_ENCOUNTERS" table
Equitable	Homeless Discharge Clothing Documentation Compliance		EMTALA - Homeless Discharge Navigator. Specifically for Clothing documented and compliance. Epic data source.
	Quality Council Health Equity Item Included in PI efforts (% of depts)		Departments that present a Health Equity (HE) -related item during Quality Council presentation / total departments presented
	Sepsis Bundle Compliance by Race	Asian	Sample of patients age >18 years, presenting in the Emergency Dept or In-patient unit with Severe Sepsis/Septic Shock (Suspected or known infection, 2+SIRS, 1 new organ dysfunction). Retrospective or concurrent chart reviews identified from one or more of the following: Emergency Room work up/differential, admitting diagnosis, Sepsis Alert, safety reporting system, EHR surveillance, iCare reporting, ICD-10 discharge code. Time of Presentation(TOP): time at which all criteria for severe sepsis are present, OR provider documentation of severe sepsis, whichever is earliest. Race is as defined of patient registration input, collected & documented in Epic.
	Sepsis Bundle Compliance by Race	Hispanic	
	Sepsis Bundle Compliance by Race	White	
	Sepsis Bundle Compliance by Race	Others	
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend		1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. 2) Inclusions: Inpatient nursing units; excludes: MBU. 3) Data run criteria, 'Top Box, Received Date, and Adjusted'
	ED - Likelihood to Recommend (PG)		ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted'
	MCH - HCAHPS Likelihood to Recommend		Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted'

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EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To:	Quality Committee of the Board
From:	Ute Burness, RN, VP of Quality, Jaideep Iyengar, MD, Co-Chair, ECHMN Quality Committee and Shahab Dadjou, President, ECHMN
Date:	August 5, 2024
Subject:	ECHMN Quarterly Quality Report

Purpose:

Provide the El Camino Hospital Board (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 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.

2. Authority: The ECHB Quality Committee is tasked with advising the ECHB regarding the quality of care provided at El Camino Hospital and its affiliated entities. Governing authority for the LLC resides with the ECHMN Board of Managers. However, the quality of care at 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 two key areas of focus for ECHMN with respect to quality and patient experience:

   A. Clinical Excellence
   B. Patient Experience (Likelihood to Recommend (LTR)

ECHMN has established true north pillars, which is quality and patient experience. ECHMN reports its ambulatory quality measures on a calendar year basis to align with Centers for Medicare and Medicaid (CMS) and major health plans/payers. The ECHMN Quality Committee is monitoring 10 quality metrics for calendar year 2024. Through June 30, the Network is on target for 5 of the measures. The measures are now displayed showing the 12-month rolling average for each measure. The quality measures are based on calendar year and reset each January. The measures also require the patient to be seen in the calendar year to be included in the measure. Looking at the data in a fiscal year view will show that most measures will show a dip in

performance in January and then the measure gets better throughout the year. The key areas of focus remain on “Controlling Blood Pressure” and “Diabetic Management of Hba1c.”
ECHMN exceeded its LTR (Likelihood to Recommend) target by 1.1 Top Box Points and all three (3) areas (Primary Care, Specialty Care and Urgent Care) met or exceeded their FY24 target. A deep dive into access was initiated in Q4 of FY24 and with the creation of our Access Taskforce, new initiatives were piloted that resulted in even more improvement in this last quarter. These will be rolled out enterprise wide in FY25 and will create more and easier access for our patients.

List of Attachments:

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

Suggested Committee Discussion Questions:

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

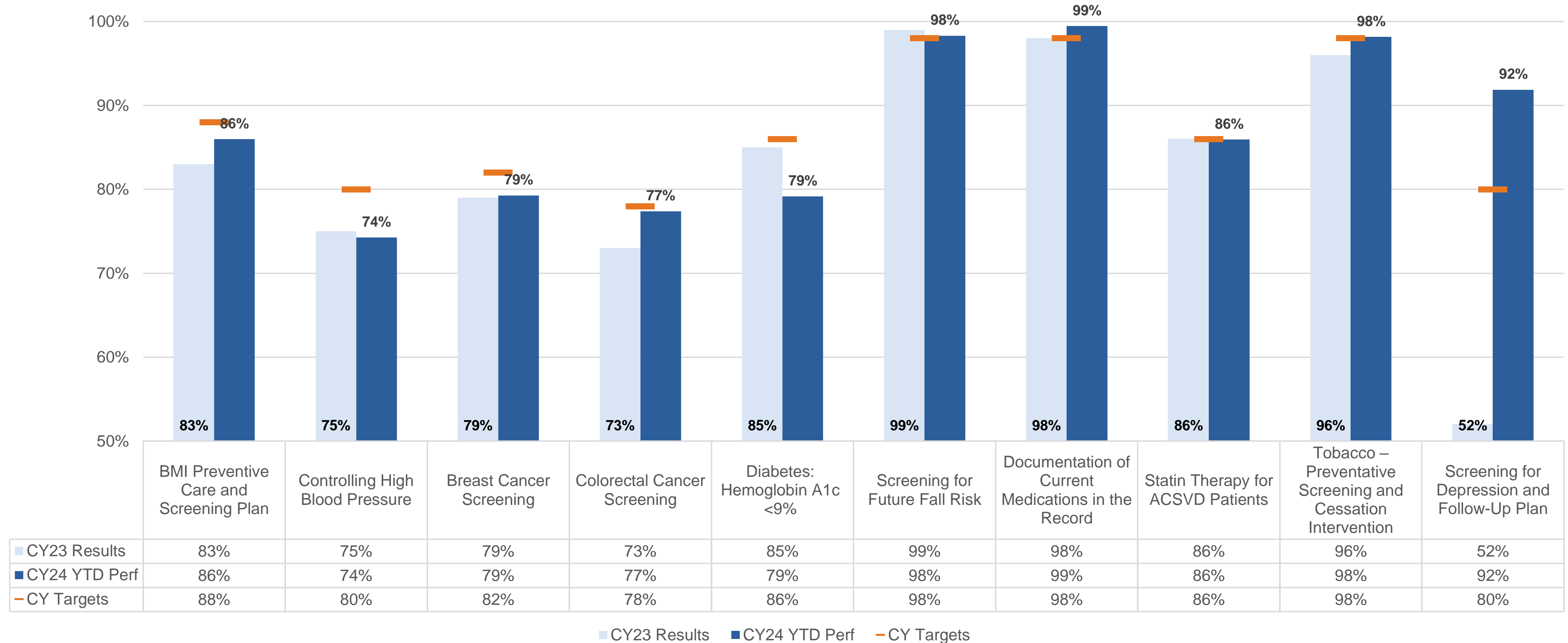
ECH Quality Committee Meeting
ECHMN Quality Update

August 5, 2024

Jaideep Iyengar, MD, Co-Chair, ECHMN Quality Committee
Ute Burness, RN, Vice President of Quality ECHMN

Clinical Domain

YTD24 thru 6/30/24 - Overall Performance vs CY23 Results



	BMI Preventive Care and Screening Plan	Controlling High Blood Pressure	Breast Cancer Screening	Colorectal Cancer Screening	Diabetes: Hemoglobin A1c <9%	Screening for Future Fall Risk	Documentation of Current Medications in the Record	Statin Therapy for ACSVD Patients	Tobacco – Preventative Screening and Cessation Intervention	Screening for Depression and Follow-Up Plan
CY23 Results	83%	75%	79%	73%	85%	99%	98%	86%	96%	52%
CY24 YTD Perf	86%	74%	79%	77%	79%	98%	99%	86%	98%	92%
CY Targets	88%	80%	82%	78%	86%	98%	98%	86%	98%	80%

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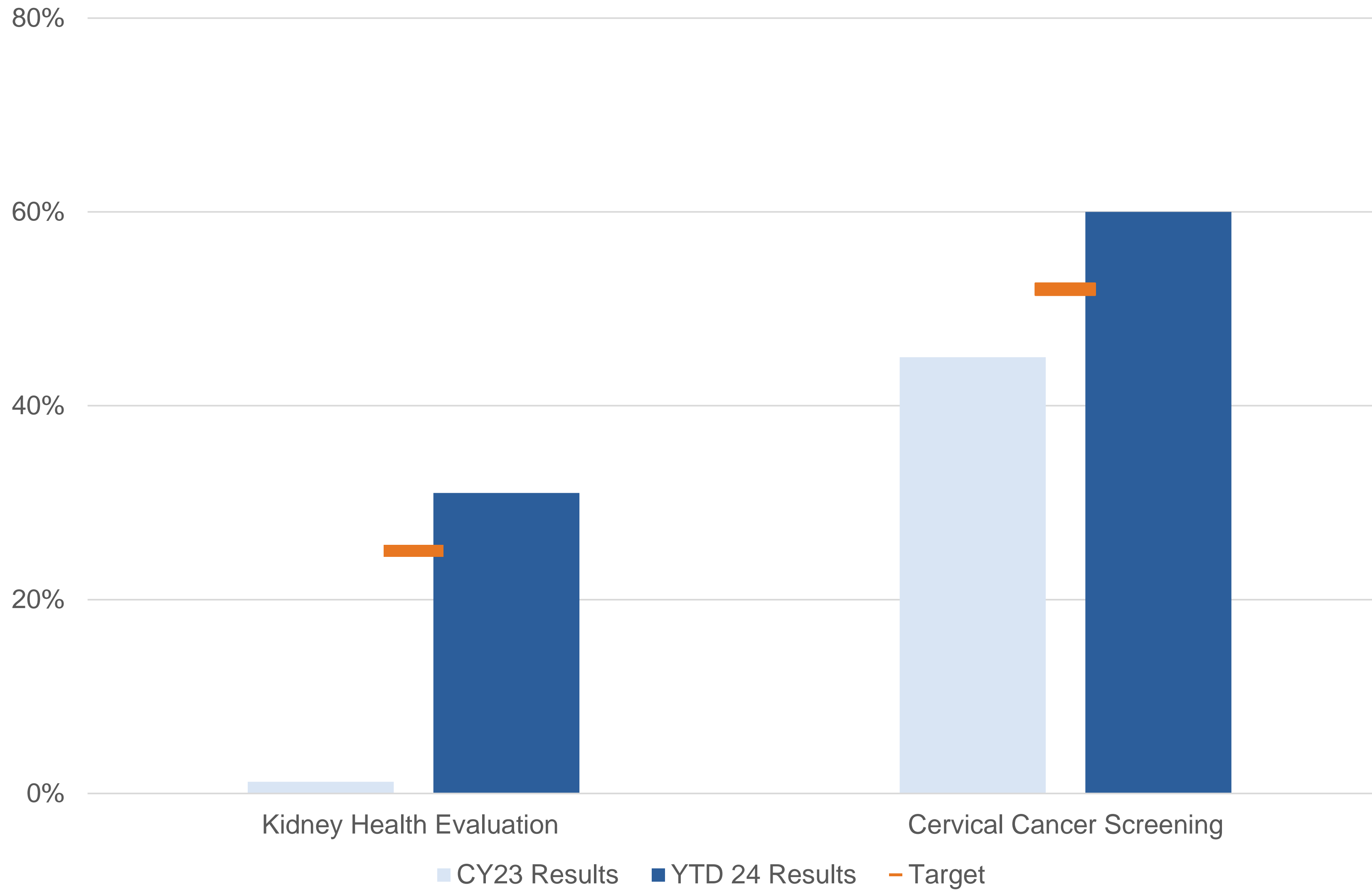
CY 2024 thru 6/30/24- Radar Quality Measures and Targets



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Calendar Year 2024 thru 6/30/24 – Core Quality Measures Trend and Actions

Core Quality Measures	CY 2024 Target	CY24 Results	12 Month Trend	Actions
BMI Preventive Care and Treatment Plan	88%	86%	90%, 85%, 80%, 75%; Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun	• Created "MA Quality Task Dashboard" in EPIC to assist the Practice Managers with auditing task completion, which went live on June 12, 2024. • Best Practice Alert (BPA) to be implementation by August 31st to indicate any patient needing screening or treatment plan. • 1/3 of the Providers are negatively impacting the score. Provider education will be done for the low performers.
Breast Cancer Screening	82%	79%	83%, 81%, 79%, 77%, 75%; Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun	• Mammogram Outreach Project workgroup –initial meeting on July 30. • EPIC report being developed to identify patients that need screening, but currently don't have an order. • PCPs will receive a list of their patients needing screenings so that they can place orders and communicate to the patients appropriately' • Breast Cancer awareness "MyChart communication" will be sent out to patients that are overdue for Breast Cancer screening to increase awareness by October 1st, 2024.
Colorectal Cancer Screening	78%	77%	84%, 74%, 64%; Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun	• EPIC report being developed to identify patients that need screening, but currently don't have an order. • PCPs will receive a list of their patients needing screenings so that they can place orders and communicate to the patients appropriately.
Controlling High Blood Pressure	80%	74%	77%, 72%, 67%; Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun	• Quality Committee to review and approve Clinical Protocols on July 25th for implementation by October 31st. • Best Practice Alert (BPA) for Specialist and Urgent Care providers to refer hypertensive patients to the PCP.
Diabetes: Hemoglobin A1c <9%	86%	79%	80%, 70%, 60%, 50%, 40%, 30%; Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun	• EPIC report being developed to identify patients that need the test, but currently don't have an order. • PCPs will receive a list of their patients needing labs so that they can place orders and communicate to the patients appropriately. • Provide standardize workflow and "Epic Tip Sheet" for point-of-care (POC) A1c monitors at pilot sites. POC A1c monitors, standardized workflow and Epic Tip Sheet to all locations by October 1st, 2024.

Results Target

Calendar Year 2024 thru 6/30/24 – Core Quality Measures Trends

Core Quality Measures	CY 2024 Target	CY 2024 Results	12 Month Trend	Notes
Documentation of Current Medications in the Record	98%	99%	99%, 97%, 95% / Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar, Apr, May, Jun	• Continue present practice and monitor this measure to ensure trend is sustained.
Tobacco – Preventative Screening and Cessation Intervention	98%	98%	100%, 95%, 90%, 85% / Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar, Apr, May, Jun	• Continue present practice and monitor this measure to ensure trend is sustained.
Screening for Future Fall Risk	98%	98%	100%, 99%, 98%, 97%, 96% / Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar, Apr, May, Jun	• Continue present practice and monitor this measure to ensure trend is sustained.
Screening for Depression and Follow-Up Plan	80%	92%	88%, 68%, 48% / Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar, Apr, May, Jun	• Continue present practice and monitor this measure to ensure trend is sustained.
Statin Therapy for ASCVD Patients	86%	86%	90%, 85%, 80% / Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar, Apr, May, Jun	• Continue present practice and monitor this measure to ensure trend is sustained.

Results Target

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Calendar Year 2024 – Radar Quality Measures and Targets Thru June 30th

Core Quality Measures	CY 2024 Target	CY 2024 Results	Year-to-Date Trend	Notes
Cervical Cancer Screening	52%	60%	65%, 60%, 55%, 50%, 45%, 40%; March, April, May, June	• Continue to monitor this measure to ensure trend is sustained.
Kidney Health Evaluation	25%	32%	40%, 30%, 20%, 10%, 0%; January, February, March, April, May, June	• Issue identified and corrected with the coding in Epic. • The Quality Measures “Best Practice Guide” provides education about the correct labs to order.

Results Target

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Calendar Year 2024 – Quality Initiatives Updates

The Quality Department is working on the following initiatives:

- Hypertension Clinical Protocol Committee: *This a sub-committee of the quality committee. The focus is to establish and implement a standardized approach for management of hypertension to include clinical protocols, patient education and enhancements to EPIC.*
  - *The sub-committee has met several times and proposed clinical protocols and patient education material which will be presented to the Quality Committee.*
  - *The patient education material was approved by the Quality Committee.*
  - *The clinical protocols will be presented to the July 25th, Quality Committee.*
  - *Best Practice Alert (BPA) and Advice Nurse work que is being developed for implementation later this yea.*
  - *Using a ECHMN-developed template, the advice nurses will help to manage these patients by documenting a self-reported blood pressure and/or facilitating a visit with their PCP if that is needed.*
- Annual Wellness Visit (AWV) Campaign: *In collaboration with the Operations team, ensure that our Medicare Advantage (MA) patients are receiving their annual wellness visits. The AWV allows us address open care gaps.*
  - *As of July 19, 59% of AWV has been completed for our Alignment patients.*
  - *The Patient Experience Coordinator has reached out to all UHC MA patients to offer an AWV appointment.*
- Clinical Operations Policy and Procedure Development and Implementation: *In collaboration with the Clinical Educator, we are implementing clinical policies and procedures to ensure consistent safe and compliant treatment of our patients.*
  - *25 clinical policies and procedures have been developed and/or updated and have been approved to the Policy committee.*
  - *Clinical staff are being trained on the clinical policies by August 30.*
- Urgent Care Quality Measures: *Develop, implement and track urgent care quality measures for continuous improvement of patient care in the urgent care setting.*
  - *The Provider view of the "Urgent Care Dashboard went live on 5/22/24.*
  - *Providers with low performance will receive additional training.*

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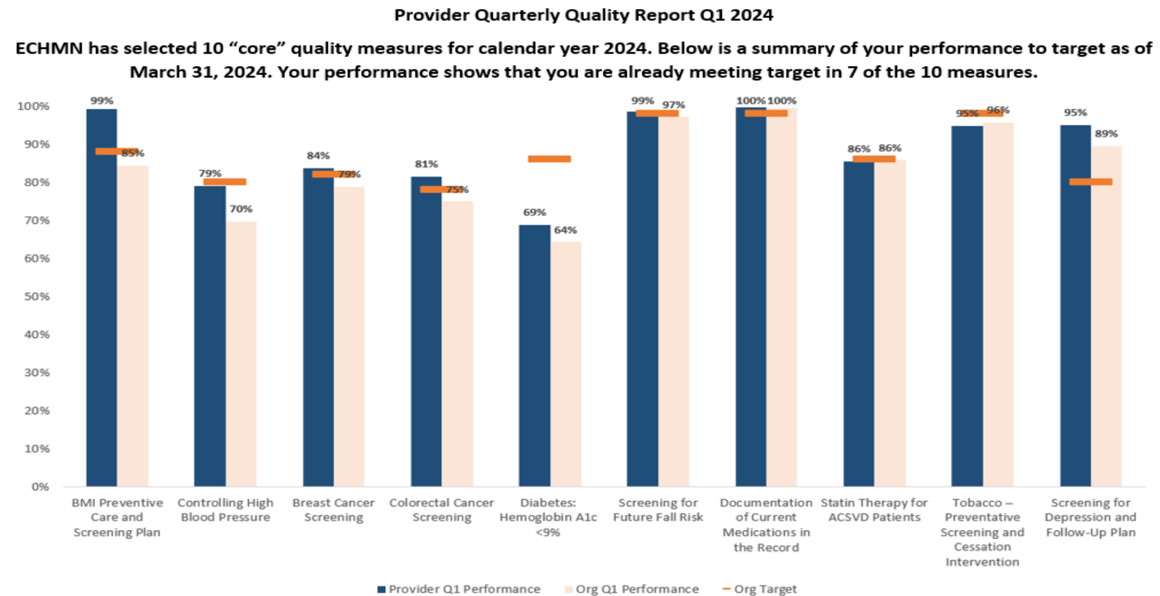
Calendar Year 2024- Quality Initiatives Updates – cont.

- Quality Assurance Performance Improvement (QAPI): *Ongoing monthly meetings with the Operations team to review quality performance, identify opportunities and implement action plans.*
  - *We have had monthly QAPI meetings.*
  - *We have streamlined collaboration between Operations and Quality to continue to improve quality measures.*

- Provider Performance Review: *Monitor and review quality performance of physicians and provide necessary training as needed.*
  - *The Quality Department developed and the ECHMN Quality Committee approved the Provider Quarterly Quality Report (PQQR).*
  - *The PQQR provides the PCPs with their individual performance on the core quality measures and a comparison to ECHMN's performance; as well as insight to improve on measures they are not meeting.*
  - *PQQRs have been sent to all PCP's for first and second quarter of this year.*



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Patient Experience Domain

FY24 ECHMN Medical Practice

ENTERPRISE	FY23 (Baseline)	FY24 Target Goals	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	FYTD	Gap to Baseline	Gap to Target
*ECHMN - All	80.7	81.3	82.2	82.5	79.4	82.9	82.4	83.4	82.8	81.6	80.8	83.8	84.3	84.3	82.4	1.7	1.1
Primary Care & Specialty Care	27	32	34	35	21	37	32	38	33	26	23	38	41	39	28		
	10017	-	1286	826	703	697	546	458	576	619	616	604	530	502	7963		
Target	-	-	81.3	81.3	81.3	81.3	81.3	81.3	81.3	81.3	81.3	81.3	81.3	81.3	81.3		
ECHMN - Primary Care	79.6	80.1	80.6	81.6	77.6	81.3	77.4	77.7	81.8	79.4	77.6	81.5	81.1	82.8	80.1	0.5	0.0
with Pediatrics	22	26	26	30	15	28	14	14	27	17	13	25	21	30	18		
	5720	-	612	396	304	336	292	238	280	339	303	308	264	256	3928		
ECHMN - Specialty Care	82.2	82.6	83.7	83.3	80.7	84.5	88.2	89.6	83.8	84.3	84.0	86.2	87.6	85.8	84.7	2.5	2.1
	34	39	44	43	26	47	77	88	39	42	40	56	70	50	42		
	4297	-	674	430	399	361	254	220	296	280	313	296	266	246	4035		
ECHMN - Urgent Care	76.1	78.0	77.2	77.6	73.8	80.0	83.3	77.5	81.6	82.1	81.9	74.5	87.1	82.9	80.2	4.1	2.2
	36	68	36	37	19	53	74	48	72	79	79	35	93	75	57		
	1323	-	158	156	107	140	162	178	228	184	188	149	140	199	1989		

49.2%

50.8%

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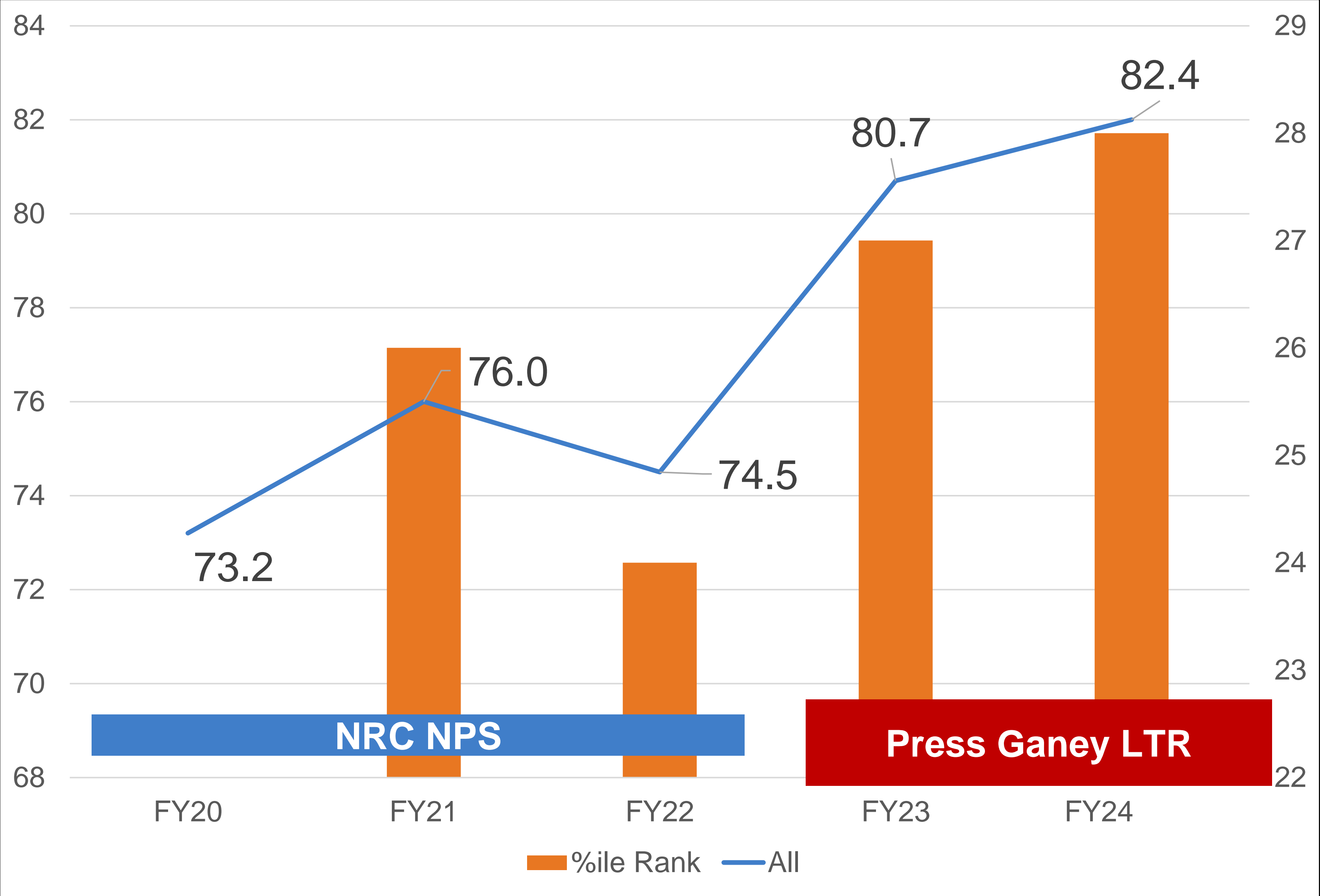
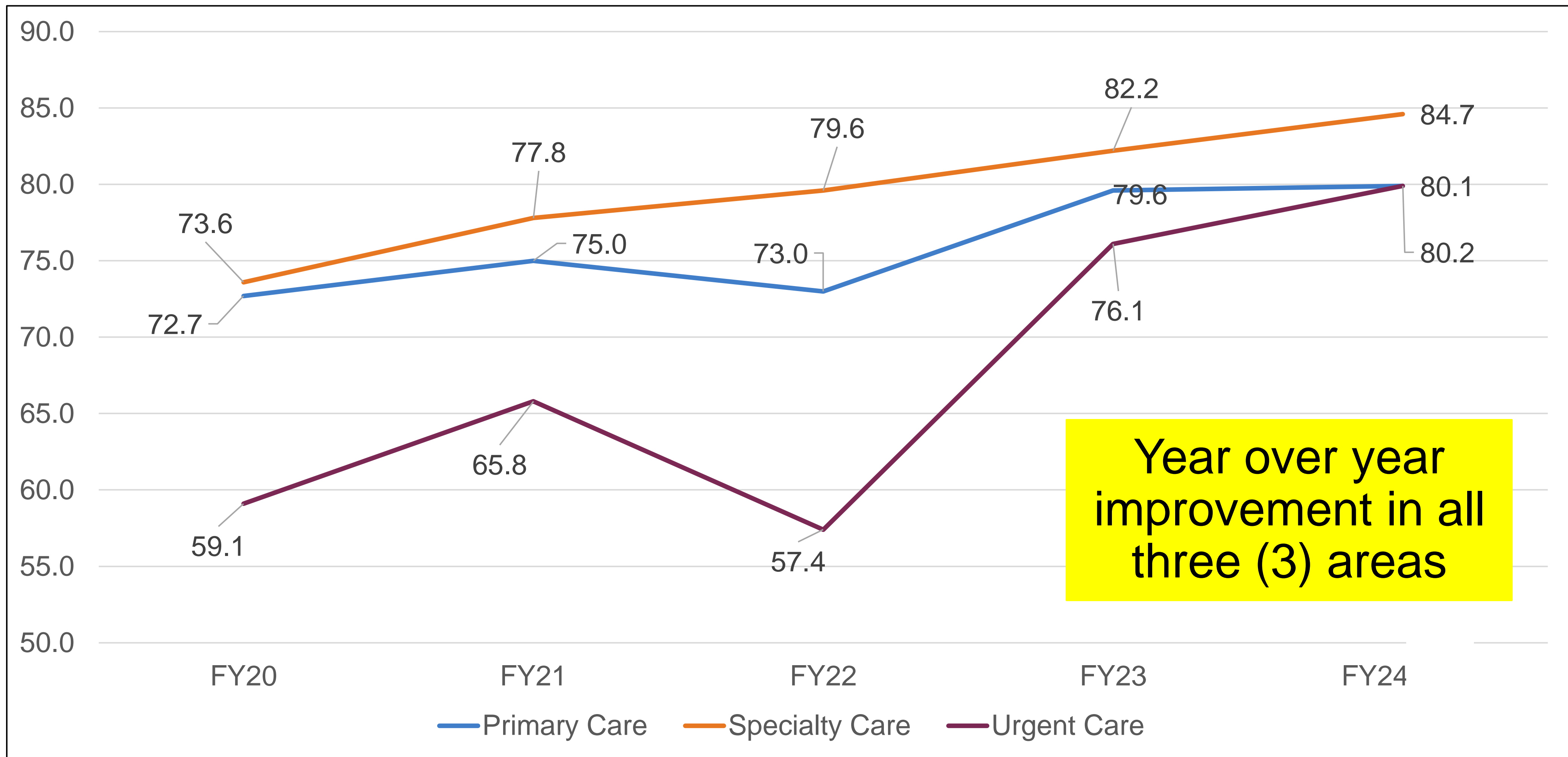
Consistent Positive Trend in Performance



Improvement shown year over year

Year over year trend by specialty



NOTE: NRC NPS FY19-FY22 & PG LTR Clinic FY23/24

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