El Camino Health

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

Monday, May 6, 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: 967 4382 0706#. No participant code. Just press #.

Pancho Chang will be participating remotely from: Room 803, Swiss Bel Inn Manyar, JL Manyar Kertoarjo 100, Surabaya , East Java 60231 Indonesia

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).

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Carol Somersille, MD Quality Committee Chair		**5:30 – 5:32 pm**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Carol Somersille, MD Quality Committee Chair	Possible Motion	**5:32 – 5:33**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair	Information	**5:33 – 5:34**
4.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. Written Public Comments *Comments may be submitted by mail to the El Camino Hospital Board Quality Committee at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	Carol Somersille, MD Quality Committee Chair	Information	**5:34 – 5:37**
5.	**CONSENT CALENDAR ITEMS** *Any Committee Member may pull an item for discussion before a motion is made.*	Carol Somersille, MD Quality Committee Chair	Motion Required	**5:37 – 5:47**
	a. Approve Minutes of the Open Session of the Quality Committee Meeting (03/04/2024) b. Approve Minutes of the Closed Session of the Quality Committee Meeting (03/04/2024) c. FY24 Pacing Plan d. CDI Dashboard e. Core Measures			

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

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
6.	**VERBAL CHAIR'S REPORT**	Carol Somersille, MD Quality Committee Chair	Information	**5:47 – 5:52**
7.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Information	**5:52 – 6:02**
8.	**EL CAMINO HEALTH MEDICAL NETWORK REPORT**	Ute Burness, VP of Quality and Payer Relations	Discussion	**6:02 – 6:22**
9.	**Q3 FY24 STEEEP DASHBOARD REVIEW/ FY24 ENTERPRISE QUALITY DASHBOARD**	Shreyas Mallur, MD, Associate Chief Medical Officer	Discussion	**6:22 – 6:42**
10.	**RECOMMEND FOR APPROVAL FY25 COMMITTEE PLANNING ITEMS:** a. Committee Dates b. Committee Goals c. Committee Pacing Plan	Shreyas Mallur, MD, Associate Chief Medical Officer	Motion Required	**6:42 – 6:57**
11.	**RECOMMEND FOR APPROVAL QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPI)**	Shreyas Mallur, MD, Associate Chief Medical Officer	Motion Required	**6:57 – 7:07**
12.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:07 – 7:08**
13.	*Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff quality assurance committee* **QUALITY COUNCIL MINUTES** a. Receive Quality Council Minutes (03/06/2024) b. Receive Quality Council Minutes (04/03/2024)	Carol Somersille, MD Quality Committee Chair	Discussion	**7:08 – 7:13**
14.	*Health and Safety Code Section 32106(b) Report on health facility trade secrets regarding new services or programs:* **OVERVIEW OF BOARD STRATEGIC PRIORITIES** a. Review FY25 Enterprise Quality and Patient Experience Goal	Dan Woods, Chief Executive Officer Shreyas Mallur, MD, Associate Chief Medical Officer	Information	**7:13 – 7:33**
15.	*Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff quality assurance committee* **Q3 FY24 QUARTERLY QUALITY AND SAFETY REVIEW OF REPORTABLE EVENTS**	Shreyas Mallur, MD, Associate Chief Medical Officer	Discussion	**7:33 – 7:43**
16.	*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*	Shreyas Mallur, MD, Associate Chief Medical Officer	Motion Required	**7:43 – 7:53**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
	RECOMMEND FOR APPROVAL CREDENTIALING AND PRIVILEGES REPORT			
17.	*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	**7:53 – 7:58**
18.	**RECONVENE TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:58 – 7:59**
19.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:59 – 8:00**
20.	**RECOMMEND FOR APPROVAL FY25 ENTERPRISE QUALITY AND PATIENT EXPERIENCE GOAL**	Shreyas Mallur, MD, Associate Chief Medical Officer	Motion Required	**8:00 – 8:02**
21.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Information	**8:02 – 8:04**
22.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	Motion Required	**8:04 – 8:05 pm**

Next Meeting: June 3, 2024

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Health Board of Directors
Monday, March 4, 2024
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Carol Somersille, MD
Melora Simon (*at 5:33 pm*)
John Zoglin
Pancho Chang
Jack Po, MD
Krutica Sharma, MD **
Prithvi Legha, MD
Philip Ho, MD

Members Absent

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
Tracy Fowler, Director, Governance Services
Nicole Hartley, Executive Assistant II
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 **5:32 p.m.** by Chair Carol Somersille. A verbal roll call was taken. A quorum was present. Dr. Krutica Sharma participated via teleconference. Melora Simon arrived at 5:33 pm.	Call to order at **5:32 p.m.**
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	Committee member Kruitca Sharma, MD participated remotely with a Just Cause exemption. Dr. Sharma confirmed that her spouse was in the room with her but that she was wearing headphones to protect the privacy of the meeting.	
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 (a) Minutes of the Open Session of the Quality Committee Meeting (02/05/2024), (b) Minutes of the Closed Session of the Quality Committee Meeting (02/05/2024), (d) Receive FY24 Enterprise Quality Dashboard, and (e) Receive Value-Based Purchasing Report. After a brief discussion, a motion was made to approve the Consent Calendar without item (b) Minutes of the Closed Session of the Quality Committee Meeting (02/05/2024), which would need to be discussed in the closed session. A robust discussion of the consent calendar ensued. a. Minutes of the Open Session of the Quality Committee The requested additions to the minutes included the following: There are plans for tracking handwashing methods by implementing unit-based champions on each shift, training, and auditing. Regarding metrics, the committee requests a timeline for when they will be met, or we will pivot to other quality improvement tactics/ideas. Regarding the ECHMN, the committee was informed that exit interviews were performed on all providers who left our organization. d. Receive Enterprise Quality Dashboard Decreased knee infections were attributed to three factors including change of irrigation, decreased OR traffic and enhanced recovery after surgery (ERAS) e. Receive Value-Based Purchasing Report The committee was educated that value based purchasing is not adequately weighted geographically. **Motion**: To approve the consent calendar minus item (b) Minutes of the Closed Session of the Quality Committee Meeting (02/05/2024) **Approval**: (a) Minutes of the Open Session of the Quality Committee Meeting (02/05/2024) **Received**: (c) Receive FY24 Pacing Plan, (d) Receive FY24 Enterprise Quality Dashboard, (e) Receive Value-Based Purchasing Report, (f) Receive Follow-Up Item: Fecal Implant **Movant**: Po **Second**: Simon **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Consent Calendar Approved***

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6. VERBAL CHAIR'S REPORT	Chair Somersille asked that the Committee think about how they would like to contribute to the Committee during the next fiscal year. Chair Somersille proposed that Committee members could make a short presentation, in place of the Chair's report, to the rest of the Committee that would highlight an area of their expertise that could be helpful to the Committee's goals and purpose.	
7. PATIENT STORY	Ms. Reinking provided the Patient's Story. Highlighted in the story was patient feedback from a patient who was being discharged and their infant's ankle monitor was not removed, causing alarms to go off in the unit. Ms. Reinking explained that the monitors are utilized for the safety of the infants, to prevent and monitor any potential attempts for infant abductions. The patient reported having a wonderful experience despite this final event. Ms. Reinking highlighted the in-depth procedures and processes for discharging infants from the hospital. Ms. Reinking updated the Committee on the steps that have been taken to ensure that staff have reviewed the discharge policies in place.	
8. PATIENT EXPERIENCE REPORT	Ms. Cunningham provided the Patient Experience Report to the Committee. Ms. Cunningham noted that staff are seeing dramatic increases across the organization's Likelihood to Recommend (LTR) metrics, even more so than the national average. Ms. Cunningham attributed this to a combination of external and internal factors and consistent in-depth observation of organizational best practices. Consistency, standard work, and focus were listed as the top three driving factors of success. Dan Woods clarified that the goal is a percentile translated into a number. The goal is to be in the top quartile as determined by Press Ganey. The Committee inquired about the planned study to be conducted for implementing translator devices in patient rooms. Staff assured that this initiative would be implemented on March 12th.	
9. FY25 ENTERPRISE COMMITTEE PLANNING ITEMS	Chair Somersille presented the FY25 Committee Planning Items, for discussion. The Committee did not have any comments on the proposed FY25 Committee meeting dates. The Committee moved to discussion on the proposed Committee goals. The Committee expressed interest in adopting a Committee goal focused on artificial intelligence. The Committee requested that attendance metrics remain in the Committee goals, subject to the creation of another governing document to uphold this metric. The Committee expressed alignment with the removal of Committee goal number four (4), subject to it being represented in another governing document. The Committee requested that Committee goal five (5) remain within the Committee goals. The Committee discussed the need for a metric to measure health disparities, listed in Committee goal three (3).	***Actions:*** *Staff to revise Committee goals with requested revisions by the Committee* *Staff to confirm that the recommendation for Board Approval of the Quality Assessment and Performance Improvement*

	The Committee requested that the Enterprise Quality Measures, contained within the pacing plan, be paced to be delivered in alignment with the STEEEP dashboard. The Committee requested that the charter language concerning the use of the El Camino Health versus El Camino Hospital be discussed and standardized for hospital committees before returning to the Committee. The committee requested more information from the Compliance Committee as suggested by the current charter. Specifically, it was requested that the Compliance Committee cooperate with the Quality Committee by reporting the results of review by regulatory and accrediting bodies and the relevant corrective actions taken. The Committee expressed the preference to keep the total number of community members allocated to serve on the Committee between 6 and 7.	*Plan is reflected in the Committee's charter*
10. FY25 ENTERPRISE QUALITY AND EXPERIENCE GOAL	The Committee discussed the FY25 Enterprise and Quality Experience Goal, proposed by management. Regarding the hand hygiene project, the Committee requested a metric be developed that is achievable and effective in its pursuit of the overall outcome of the project. Additionally, the Committee discussed with staff the possibility of adding an observable patient experience metric. Staff agreed to discuss and return this to the Committee.	
11. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session at 7:36 pm **Movant**: Zoglin **Second**: Simon **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Recessed to Closed Session at 7:36 PM***
12. AGENDA ITEM 16: CLOSED SESSION REPORT OUT	During the closed session, the Quality Committee approved the Minutes of the Closed Session of the February 5th, 2024 Quality Committee Meeting and 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.	
13. AGENDA ITEM 17: COMMITTEE ANNOUNCEMENTS	There were no additional announcements from the Committee.	

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14. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 7:54 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 7:54 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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El Camino Health

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Minutes of the Closed Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Health Board of Directors
Monday, March 4, 2024
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Carol Somersille, MD
Melora Simon (*at 5:33 pm*)
John Zoglin
Pancho Chang
Jack Po, MD
Krutica Sharma, MD **
Prithvi Legha, MD
Philip Ho, MD

Members Absent

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
Tracy Fowler, Director, Governance Services
Nicole Hartley, Executive Assistant II
Gabriel Fernandez, Coordinator, Governance Services

**via teleconference

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER	The closed session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Health (the "Committee") was called to order at **7:36 pm** by Chair Somersille. A quorum was present. Dr. Krutica Sharma participated via teleconference.	
2. AGENDA ITEM 11a: CLOSED SESSION MINUTES OF THE FEBRUARY 5TH QUALITY COMMITTEE MEETING	**Motion:** To approve the Closed Session Minutes of the February 5th, 2024 Quality Committee Meeting **Movant**: Legha **Second**: Simon **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Actions:*** *Staff to revise Closed Session minutes with requested revisions*
3. AGENDA ITEM 11: QUALITY COUNCIL MINUTES	The Committee requested that directors who are members of the Quality Council be encouraged to attend. The Committee made a general inquiry into the critical care annual performance, improvement update. The Committee asked for further discussion on the variable performance between both campuses, highlighting performance in the ICU at the Mountain View Campus. Discussion centered on the sharing of best practices among campuses	

4. AGENDA ITEM 13: APPROVE CREDENTIALING AND PRIVILEGES REPORT	**Motion:** To recommend to the Board to approve the Credentialing and Privileges Report **Movant**: Simon **Second**: Po **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Credentialing and Privileging report approved***
5. AGENDA ITEM 14: VERBAL SERIOUS SAFETY/ RED ALERT EVENTS	Staff shared that there were no serious safety/ red alert events to report to the Committee.	
6. AGENDA ITEM 15: RECONVENE OPEN SESSION	**Motion:** To reconvene to Open Session at 7:53 p.m. **Movant**: Chang **Second**: Legha **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Reconvened Open Session at 7:53 p.m.***

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

_____

Gabriel Fernandez, Governance Services Coordinator

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

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El Camino Health

APPROVED BY
QC 4/3/2023

Quality, Patient Care, and Patient Experience Committee
FY24 Pacing Plan

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
STANDING AGENDA ITEMS												
Consent Calendar[1]		✓	✓		✓	✓		✓	✓		✓	✓
Patient Experience Story		✓	✓		✓	✓		✓	✓		✓	✓
Serious Safety/Red Alert Event (as needed)		✓	✓		✓	✓		✓	✓		✓	✓
Credentialing and Privileges Report		✓	✓		✓	✓		✓	✓		✓	✓
SPECIAL AGENDA ITEMS – OTHER REPORTS												
Quality & Safety Review of reportable events		✓			✓			✓			✓	
Board STEEP Dashboard Review		✓			✓			✓			✓	
El Camino Health Medical Network Report		✓			✓			✓			✓	
Annual Patient Safety Report			✓									
Annual Culture of Safety Survey Report			✓									
Patient Experience			✓						✓			
Health Care Equity						✓						✓
Safety Report for the Environment of Care					✓							
PSI Report						✓						
Sepsis Review						✓						
Value Based Purchasing Report									✓			
Approve Quality Assessment & Performance Improvement Plan (QAPI)												✓
Refresh STEEEP Dashboard measures for FY25			✓									
COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR												
Propose Committee Goals									✓			
Approve Committee Goals											✓	
Propose FY Committee Meeting dates									✓			
Approve FY Committee Meeting dates											✓	
Propose Organizational Goals									✓			
Approve Organizational Goals											✓	
Propose Pacing Plan									✓			
Approve Pacing Plan											✓	
Review Charter									✓			
Approve Charter											✓	

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

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: Cornel Delogramatic, Director of Clinical Documentation Integrity and Health Equity
Date: May 6, 2024
Subject: Clinical Documentation Integrity Dashboard FY 2021 – 2024

Purpose:

To provide a semi-annual update on the Clinical Documentation Integrity Department activity.

Summary:

1. Situation: From a clinical perspective, CDI ensures accurate descriptions of health conditions and creates electronic documents for every step of the patient's treatment and services that translates into quality outcomes (mortality score, readmission score, complication score, etc.), patient safety measures (PSI rate, HAC rate,) and utilization outcomes (expected LOS, denial rate, clean claim rate, RAF scores, CMI etc).

2. Authority: Quality Committee of the Board is responsible for oversight of Clinical Documentation Integrity Department.

3. Background: The Clinical Documentation Integrity (CDI) department is critical to a hospital because it ensures that clinical documentation accurately tells the patient's story and that the records of each patient and their medical history are maintained for future use. CDI programs can aid in the documentation of diagnoses that are specific and consistent throughout the medical record, which leads to accurate code assignment, better understanding of patient complexity, and improved safety and quality scores. Additionally, a well-trained clinical documentation integrity team will use consistent processes to promote accurate claims, which will reliably result in full reimbursement for rendered care services, reduce denials and improved appeal processes for the organization.

4. Assessment: Each medical record is reviewed by a clinical documentation specialist (CDS) who identifies documentation deficiencies or opportunities and uses a communication tool named "clinical documentation query" to communicate with the physicians to correct the deficiencies or to validate the diagnoses/procedures clinically. The CDI team is also responsible for educating the providers on documentation compliance requirements or newly emerged diagnostic guidelines, clinical classifications, and risk adjustment methodologies. Each query is stored within EMR as a part of the legal medical record.

In this dashboard, each metric that is higher is better and is highlighted in green.

5. Other Reviews:

6. Outcomes:

A. CDI review coverage rate – Inpatient population; (process measure)
B. CDI review coverage rate – Outpatient population; (process measure)

C. CDI query volumes and provider meaningful responses; (process and engagement measure)
D. PSI/HAC exclusion rates; (outcome measure)
E. Nv-HAP exclusion rates; (outcome measure)
F. Expected mortality rate at ECH; (clinical documentation derivative)
G. Expected readmission rate at ECH; (clinical documentation derivative)

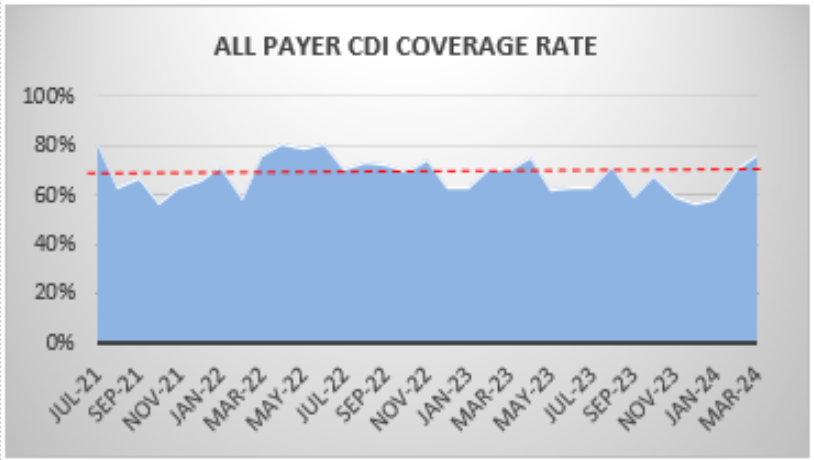
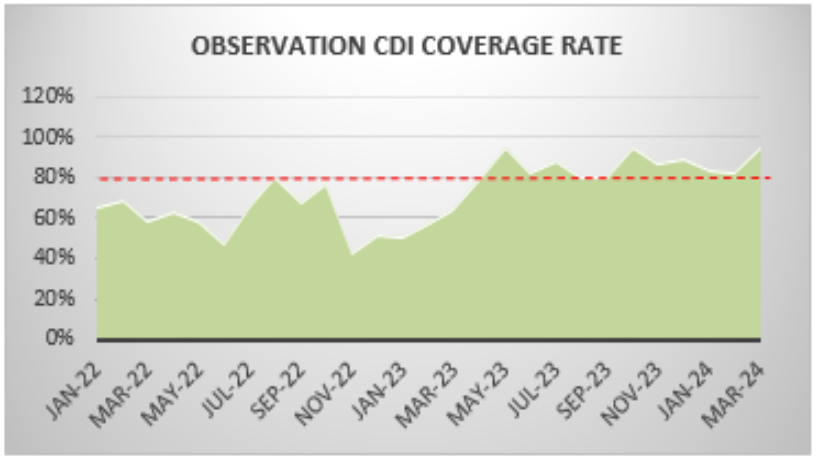
List of Attachments:

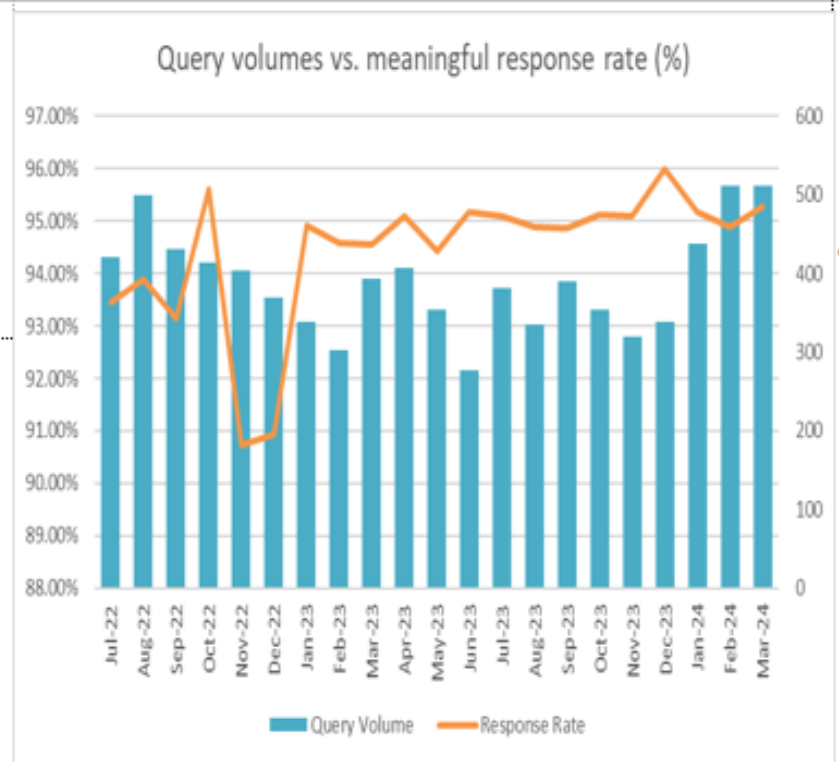
1. CDI Dashboard FY24.

Suggested Committee Discussion Questions: None

El Camino Health

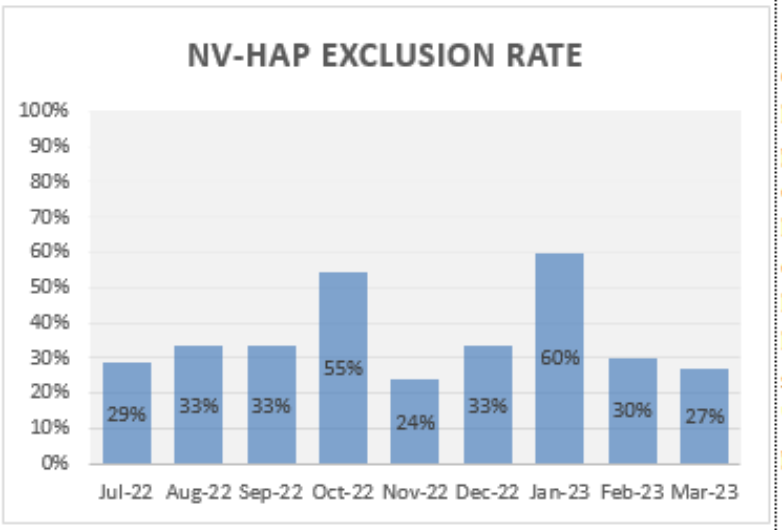
Clinical Documentation Integrity Dashboard (Monthly/ ALL adult, acute care, non-OB inpatient population)

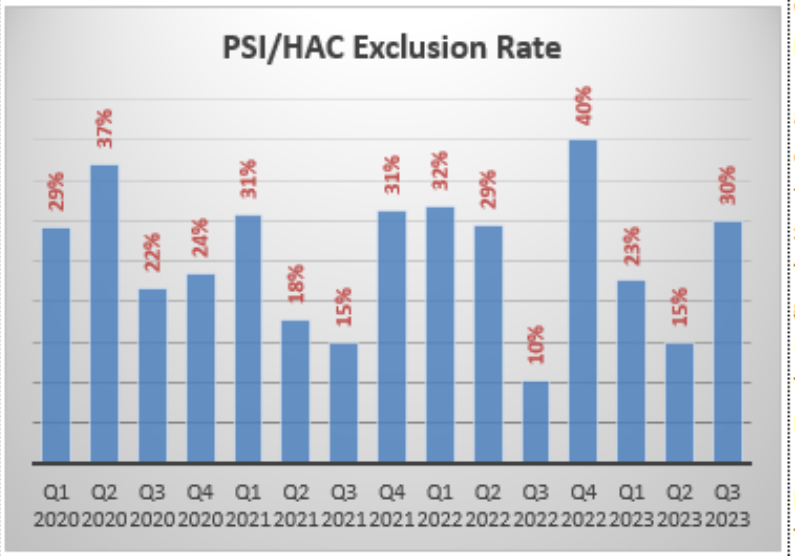
As of April 15, 2024			Baseline	FY24 Goal	Trend	Comments
	CDI Coverage	Performance	FY2023	FY2024 goal		
1	**All Payer CDI coverage rate** *Source: iCare CDI Productivity report	**March 2024** 76% **FYTD** 69%	69%	70%		All-payer coverage demonstrates the effectiveness of the CDI Team. Currently, we have 4.5 FTEs covering all adult non-OB patients on both campuses. That is approximately 1300 to 1500 patients per month. We will continue implementing technologies to increase our productivity in FY 2024.
2	**Observation CDI Coverage Rate** *Source: iCare CDI Productivity report	**March 2024** 96% **FYTD** 87%	67%	75%		Observation review is essential for many aspects of the organization. By having clinical documentation specialists review these cases, we ensure that clinical documentation accurately reflects the medical necessity in the medical record and that all comorbidities are coded and clinically validated.

Physician engagement		Performance		FY2023	FY 2024 goal	
3	**Query volumes** **Source: iCare CDI Query report*	**March 2024 512**	**FYTD 397**	367	400	
4	**Meaningful Response Rate** **Source: iCare CDI Query report*	**March 2024 95%**	**FYTD 94%**	87%	91%	

This metric is intended to assess physician engagement with CDI efforts within our health system by measuring the meaningful response rate compared to the total query volumes. Historically, CDI programs have shown progressive improvement in this metric within the past four years, increasing from 67% in FY 2019 to 94% YTD. Mainly it is up-trending due to strong CDI-MD collaboration and education around excellent clinical documentation benefits to the organization.

CDI Quality Outcomes		Performance		FY2023	FY 2024 goal
5	**nv-HAP exclusion rate** *Source: CDI nv--HAP dashboard*	**March 2024** **32%**	**FYTD Avg.** **36%**	**30%**	**30%**
6	**PSI/HAC exclusion rate** *Source: CDI PSI/HAC Dashboard	**Q4 2023** **31%**	**FYTD Avg.** **25%**	**26%**	**30%**





Nv-HAP is a central component of the HAC Quality Index. CDI team provides support by ensuring that each hospital-acquired pneumonia case is scrutinized and potential documentation challenges are clarified before being final coded and released for data collection. It is one of the many benefits a solid and experienced CDI team brings to the organization's quality and safety of care. A high exclusion rate of "false" labeled hospital-acquired cases of pneumonia positively impacts our HAC Index.

Another aspect of CDI's impact on the quality of care and how that gets reported publicly is by reviewing Patient Safety Indicator (PSI) labeled cases and hospital-acquired conditions (HAC) and trying to clarify with the physician if any exclusion factors existed that could precipitate such safety events. By continuously monitoring these cases, the CDI team ensured our data gets reported accurately to federal reporting agencies and third-party entities that broadcast hospital ratings to the public. A high exclusion rate of inaccurately documented complications positively impacts our patient's care and the public's image of our institution.

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: Lyn Garrett, MHA, MS, CPHQ, Senior Quality Director
Date: May 6, 2024
Subject: Calendar Year 2023 Core Measure Dashboard

Purpose:

To update the Quality, Patient Care, and Patient Experience Committee on CY 2023 Core Measure Dashboard, Non-Hospital-based Inpatient Psychiatric Services Non-HBIP and Hospital-based Inpatient Psychiatric Services (HBIPS).

Summary: As required under section 1890A(a)(6) of the Social Security Act, Centers for Medicare and Medicaid Services (CMS) assesses the quality and efficiency of care provided to patients through establishing quality standards and programs to improve health care for beneficiaries and all who receive care in the United States. Core measures are designed to be meaningful to patients, consumers and physicians. CMS uses core measure performance to inform how we are graded in various quality initiatives such as pay for reporting, value based pay, and public reporting on Care Compare (https://www.medicare.gov/care-compare/) previously known as Hospital Compare.

1. Authority: The Quality, Patient Care, and Patient Experience Committee of the Board is responsible for the quality and safety of care provided to ECH patients. This dashboard provides oversight on compliance with CMS measurements of clinical quality.

2. Background: There are no new revisions for CY 2023 by CMS or the Joint Commission (TJC) to the core measures. Some metrics are measured as eCQM (electronic Clinical Quality Measure) reporting in accordance with CMS "Meaningful Use" program. Sepsis (SEP-1) Core Measure is reported as its own dashboard. These measures only reflects Inpatient Quality Reporting (IQR) and some Outpatient Quality Reporting (OQR) Program Measures.

3. Assessment: CMS has two sets of Core Measures relevant to El Camino Health acute care: one covers acute hospitals (Non-HBIPS) and the second only applies to acute hospitals with inpatient behavioral health units, which is called HBIPS (Hospital-based Inpatient Psychiatric Services).

A. Non-HBIPS Core Measures (Non**-** Hospital-based Inpatient Psychiatric Services**)**

i. **PC01- Elective Delivery (EED)** Prior to 39 weeks gestation- Percent of mothers with elective vaginal deliveries or elective cesarean births at >=37 and < 39 weeks gestation completed. This measure shows the percentage of pregnant individuals who had elective deliveries 1-2 weeks early (either vaginally or by C-section) whose early deliveries were not medically necessary. Higher numbers may indicate that hospitals aren't doing enough to discourage this unsafe practice. CY23 ECH Target = 1.5%, CY 2023 Performance: 2.02% (6/297). Hospital Compare reporting period Q32022-Q22023 PC-01 - ECH 1%; national 2% and state 2%. TJC is at <2%. We are currently in the sustainment phase with this measure.

ii. **PC02- Cesarean Birth**- Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. Target goal of 23.9%; CY 2023 Performance is 25.9% (570/2197). Leapfrog is following Healthy People 2020 NTSV cesarean birth rate target of 23.9% and 23.6% or less by 2030. OB Task Force is working to identify where we can make system improvements to reduce unnecessary NTSV. MCH leadership team has worked with independent OBs and OB groups to identify practice patterns and opportunities for improvement. Their data is showing steady progress. The following are actions taken by MCH Service Line, OB

- Quarterly unblinded data to OBs, also distributed data to RNs.
- Support for outlier OBs provided
- Implemented CMQCC NTSV checklist
- Provided OB and RN education (positioning)
- Implemented CMQCC NTSV checklist
- Developed class for S. Asian pts (largest population with high rate)
- Developing NTSV case review process (bi-weekly)
- Evaluating doula integration programs, developing Doula list for patients.
- In the process of offering TENS units for labor pain support, policy pending.

iii. **PC05- Exclusive Breast Milk Feeding**- Newborns that were fed breast milk only since birth during the entire hospitalization. ECH Target goal is 65.1% (CMQCC 50th percentile). CY 2023 Performance: 67.6% (558/826) which is above TJC's rate of 50%. Below are the actions taken by MCH Service Line, Normal Newborn

- Monitoring monthly breastfeeding rates on both campuses, including identifying outliers of nursing staff who offer more first formula than colleagues do.
- Refine the banked donor milk for term infants rollout to improve nursing and MD workflow, increasing use of donor milk instead of formula if supplementation needed or requested.
- LG to complete their Baby Friendly re-designation process.
- Continue with the interdisciplinary Baby Friendly Designation process in MV including training of staff and providers, updating the infant feeding policy, and expanding prenatal breastfeeding education. Senate Bill 402, De Leon, Health and Safety Code 123367; Requires all general acute care hospitals and special hospitals with perinatal units to adopt, by January 1, 2025, The Ten Steps to Successful Breastfeeding adopt baby friendly 10 steps to successful breastfeeding.

iv. **PC06- Unexpected Complications in Term Newborns**- this measure is intended to track moderate-to-severe adverse outcomes of healthy infants without preexisting conditions. ECH Target goal is 0%; CY 2023 Performance: 2.2% (90/4033) compared to TJC's 3%. This measure is not publicly reported yet. The cases that failed the measures are forwarded to

peer review for further assessment. All cases of sever UNC are reviewed in detail and changes implemented if opportunities identified.

v. **OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients**-Median time (in minutes) patients spent in the emergency department before leaving from the visit. ECH Target goal is 180 minutes or less; CY 2023 rate is ENT:174 minutes. Latest Hospital Compare - ECH 178 minutes, California 194 minutes, and National average-212 minutes with reporting period Q32022-Q22023.

vi. **OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke**- Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival. ECH Target goal is 100%; CY 2023 performance is 0% (0/3). This measure has a very low volume. The number of patients/cases is too few as reported on Medicare Care Compare website. CY23 data was presented to Stroke Committee March 14th meeting. It was acknowledged that all three patients were not admitted and had resolved/resolving symptoms on arrival. Unfortunately, OP-23 does not have exclusion criteria for this type of case. No other reasons for delay were shared.

B. **<u>HBIPS Core Measures (</u>**Hospital-based Inpatient Psychiatric Services)

i. **IMM-2 Influenza Immunization** - Patients assessed and given influenza vaccination. ECH Target goal is 100%; CY 2023 rate is 91.1% (367/403) CY2023 compliance dropped compared to CY2022 r/t Influenza vaccine not given-no justification documented. MHAS team is now receiving daily epic emails to notify them of patients who need a vaccination.
Latest Hospital Compare - IMM-2 Influenza ECH is 96% California rate 82%; National 77% with reporting period 4Q2022-1Q2023.

ii. **HBIPS-5 Patients Discharged on multiple antipsychotic medications with appropriate justification**. ECH Target goal is 80% CY 2023 rate is 34.3%. This measure was retired effective January 1, 2024, discharges. CMS assessed the guidelines that originally supported the HBIPS-5 measure have changed substantially, and the HBIPS-5 measure is no longer aligned with current clinical guidelines and practice.
Furthermore, the HBIPS-5 measure is no longer supported by the measure steward (that is, The Joint Commission), who withdrew it from the endorsement process in 2019.

iii. **PC-TOB Perfect Care - Tobacco Use**- ECH Target goal is 80% CY 2023 rate is 30.8%. Patients are not receiving all components of practical counseling prior to discharge AND referral for outpatient tobacco cessation counseling not offered at D/C. Quality team began monthly meetings with the MHAS team in November 2023. Great discussion on barriers and challenges they face. There is now a better understanding of requirements for each subsection measure.

iv. **PC-SUB Perfect Care - Substance Abuse**- This measure shows the percentage of patients hospitalized in an inpatient psychiatric facility aged 18 years and older with alcohol or drug use disorder who, when discharged, received or refused medications to treat their alcohol or drug use OR who received or were offered a referral for addiction treatment. ECH Target goal is 80% CY 2023 rate is 72.5%. MHAS team is engaging providers to better understand the measure and the workflow to increase compliance.

v. **TR-1 Transition Record with Specified Elements Received by Discharged Patients.** ECH Target goal is 75% CY 2023 rate is 88.4%.

vi. **MET-1 Screening for Metabolic Disorders** - Comprehensive screening currently defined to include: Body mass index, A1C or glucose test, Blood pressure, Lipid panel, Total cholesterol Low density lipoprotein, High density lipoprotein, Triglycerides. ECH Target goal is 75%; CY 2023 rate is 94.4%.

vii. **HBIPS-2 Hours of Physical Restraint Use (per 1000 patient hours)** lower is better. ECH Target goal is 0.0004; CY 2023 rate is 0.0003.

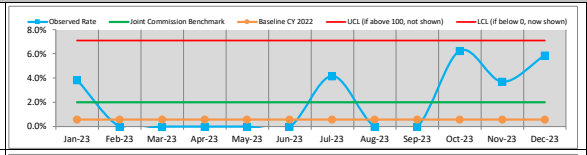
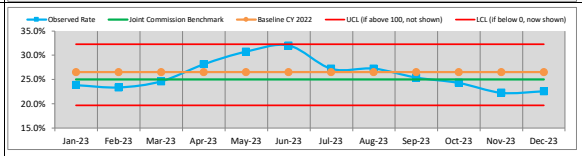
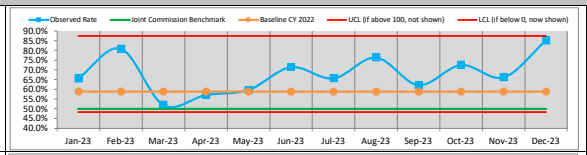
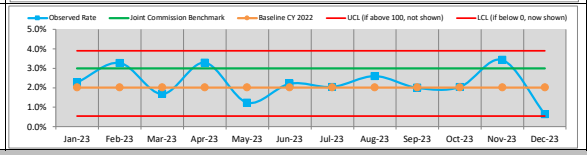
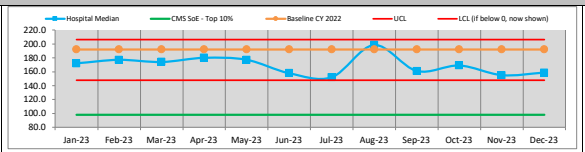
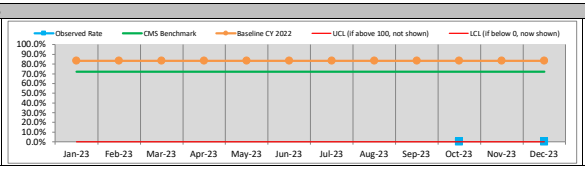
viii. **HBIPS-3 Hours of Seclusion Use (per 1000 patient hours**) lower is better ECH Target goal is 0.0003; CY 2023 rate is 0.0002.

List of Attachments:

1. Attachment 1: CY2023 Core Measure Report Non-HBIPS for GB
2. Attachment 2: CY2023 Core Measure Report HBIPS for GB

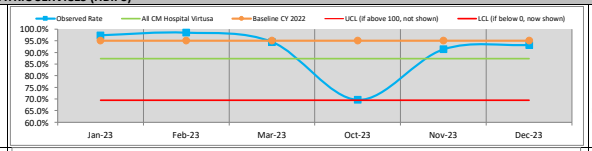
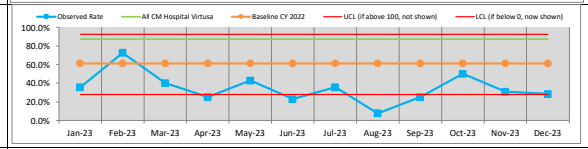
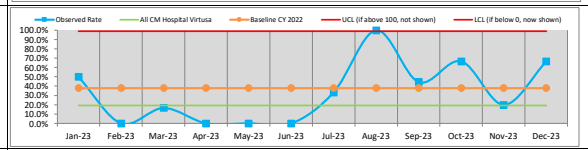
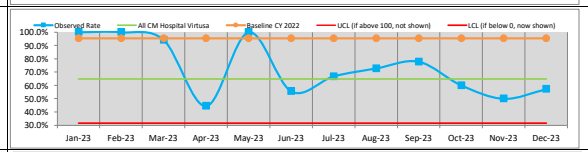
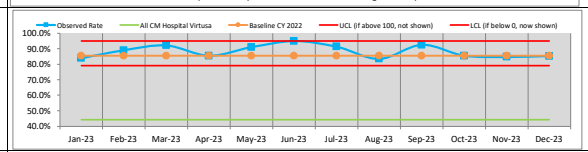
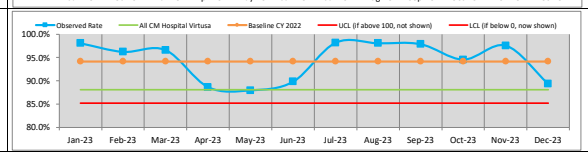
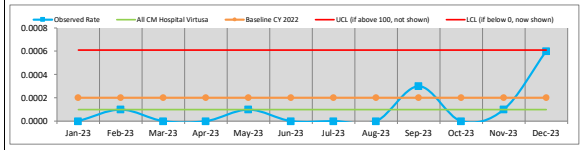
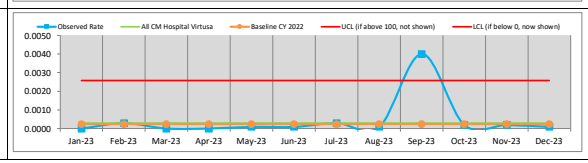
El Camino Health

Core Measures Dashboard (non-HBIPS) - CY 2023 Performance - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	CY 2023 Performance	CY 2022 Baseline	Target	Trend Graph	CY 2023 Definition	Definition Owner	Work Group	Source
PERINATAL CARE MOTHER									
PC-01 Elective Delivery Prior to 39 weeks gestation (lower = better) **FINALIZED** Data Source : Virtusa Latest Data Month: December 2023	ENT: 5.9% (2/34) MV: 8.0% (2/25) LG: 0.0% (0/9)	ENT: 2.02% (6/297) MV: 2.02% (5/248) LG: 2.04% (1/49)	ENT: 0.59% (2/337) MV: 0.39% (1/256) LG: 1.23% (1/81)	< 2% (Joint Commission Benchmark)		Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	TJC	Monthly meeting/emails with L&D nursing leadership; failure summary cases referred to peer review coordinator	Virtusa CareDiscovery Quality Measures
PC-02 Cesarean Birth (lower = better) **FINALIZED** Data Source : Virtusa Latest Data Month: December 2023	ENT: 22.6% (37/164) MV: 21.9% (32/146) LG: 27.8% (5/18)	ENT: 25.9% (570/2197) MV: 27.0% (518/1916) LG: 18.5% (52/281)	ENT: 26.5% (590/2226) MV: 27.8% (515/1850) LG: 19.9% (75/376)	< 25% (Joint Commission Benchmark)		Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	TJC	Monthly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator	Virtusa CareDiscovery Quality Measures
PERINATAL CARE BABIES									
PC-05 Exclusive Breast Milk Feeding **FINALIZED** Data Source : Virtusa Latest Data Month: December 2023	ENT: 85.2% (52/61) MV: 86.0% (49/57) LG: 75.0% (3/4)	ENT: 67.6% (558/826) MV: 67.0% (485/724) LG: 71.6% (73/102)	ENT: 58.9% (505/858) MV: 57.0% (407/714) LG: 68.1% (98/144)	> 50% (Joint Commission Benchmark)		Numerator Statement: Newborns that were fed breast milk only since birth Denominator Statement: Single term newborns discharged alive from the hospital	TJC	Quarterly meeting/emails with L&D nursing leadership	Virtusa CareDiscovery Quality Measures
PC-06 Unexpected Complications in Term Newborns (lower = better) **FINALIZED** Data Source : Virtusa Latest Data Month: December 2023	ENT: 0.6% (2/316) MV: 0% (0/274) LG: 4.8% (2/42)	ENT: 2.2% (90/4033) MV: 1.96% (68/3462) LG: 3.9% (22/571)	ENT: 2.0% (84/4182) MV: 1.8% (63/3425) LG: 2.8% (21/757)	< 3% (Joint Commission Benchmark)		Numerator Statement: Newborns with severe complications and moderate complications Denominator Statement: Liveborn single term newborns 2500 gm or over in birth weight. This measure simply asks: of babies without preexisting conditions (no preemies, multiple gestations, birth defects or other fetal conditions) and who are normally grown and were not exposed to maternal drug use, how many had severe or moderate neonatal complications?	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator	Virtusa CareDiscovery Quality Measures
ED THROUGHPUT									
OP-18b Median Time from ED Arrival to ED Departure for Discharged ED Patients (lower = better) **FINALIZED** Data Source : Virtusa Latest Data Month: December 2023	ENT: 158 Minutes	ENT: 174 Minutes	ENT: 192 Minutes	< 98 mins (CMS Standard of Excellence - Top 10% of Hospitals)		"Numerator -Time (in minutes) from ED arrival to ED departure for patients discharged from the ED - Reporting Measure Denominator -Any ED Patient from the facility's emergency department, not expired Included Populations: Any ED patient from the facility's emergency department Excluded Populations: Patients who expired in the emergency department"	Hospital OQR Specifications Manual		Virtusa CareDiscovery Quality Measures
OUTPATIENT MEASURES									
OP-23 Head CT or MRI Scan Results fro Acute Ischemic Stroke or Hemorrhagic Stroke **FINALIZED** Data Source : Virtusa Latest Data Month: December 2023	ENT: 0.0% (0/2) MV: 0.0% (0/2) LG: - No Cases	ENT: 0.00% (0/3) MV: 0.00% (0/3) LG: - No Cases	ENT: 83.3% (10/12) MV: 100% (9/9) LG: 33.3% (1/3)	100% (CMS Standard of Excellence - Top 10% of Hospitals)		Numerator -ED Acute Ischemic or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the time last known well, with an order for a head CT or MRI scan whose time from ED arrival to interpretation of the Head CT scan is within 45 minutes of arrival Denominator -ED Acute Ischemic or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the time last known well with an order for a head CT or MRI scan	Hospital OQR Specifications Manual	Shared with Christine Kilkenny (monthly) /Stroke Committee (quarterly prn)	Virtusa CareDiscovery Quality Measures

El Camino Health

Calendar Year 2023 Performance - Core Measures (HBIPS) - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	CY 2023 Performance	CY 2022 Baseline	All Core Measures Hospitals Jan-Dec 2023 Benchmark	Trend Graph	CY 2023 Definition	Definition Owner	Work Group	Source
HOSPITAL BASED INPATIENT PSYCHIATRIC SERVICES (HBIPS)									
IMM-2 Influenza Immunization **FINALIZED** *Data Source : Virtusa* *Latest Data Month: December 2023* ***Data only captured for Jan-Mar, Oct - Dec months**	93.3% (56/60)	91.1% (367/403)	95.1% (391/411)	87.4%		Numerator: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated. Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October through March. Excludes patients less than 6 months of age, patients who expire prior to hospital discharge, patients with an organ transplant during the current hospitalization, patients with hospital discharges Oct 1 through March 31 when the provider's vaccine supply is on order but has not yet been received, patients who are transferred or discharged to another hospital, or patients who leave AMA. Definition: Documentation of the patient's vaccination status during this influenza season. If found to be a candidate for the influenza vaccine, documentation that the influenza vaccine was given during this hospitalization.	**CMS/TJC**	**monthly meeting/ email to MHAS team**	**Virtusa CareDiscovery Quality Measures**
HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification **FINALIZED** *Data Source : Virtusa* *Latest Data Month: December 2023*	28.6% (2/7)	34.3% (47/137)	61.3% (73/119)	62.7%		Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification Denominator Statement: Psychiatric inpatient discharges	**TJC**	**monthly meeting/ email to MHAS team**	**Virtusa CareDiscovery Quality Measures**
PC-TOB Perfect Care - Tobacco Use **FINALIZED** *Data Source : Virtusa* *Latest Data Month: December 2023*	66.7% (2/3)	30.8% (16/52)	38.0% (27/71)	19.4%		No tob 1 , same Tob 2 and 3	**TJC**	**monthly meeting/ email to MHAS team**	**Virtusa CareDiscovery Quality Measures**
PC-SUB Perfect Care - Substance Abuse **FINALIZED** *Data Source : Virtusa* *Latest Data Month: December 2023*	57.1% (4/7)	72.5% (95/131)	95.3% (122/128)	64.8%		No Sub 1, same SUB 2 and 3	**TJC**	**monthly meeting/ email to MHAS team**	**Virtusa CareDiscovery Quality Measures**
TR-1 Transition Record with Specified Elements Received by Discharged Patients **FINALIZED** Data Source : Merative Latest Data Month: December 2022	85.2% (52/61)	88.4% (777/879)	85.5% (720/842)	44.3%		Numerator: Psychiatric inpatients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all 11 required elements. Denominator: Psychiatric inpatients, regardless of age, discharged from the IPF to home/self-care or any other site of care.	**CMS/TJC**	**monthly meeting/ email to MHAS team**	**Virtusa CareDiscovery Quality Measures**
MET-1 Screening for Metabolic Disorders **FINALIZED** Data Source : Virtusa Latest Data Month: December 2023	89.4% (42/47)	94.4% (587/622)	94.2% (533/566)	88.1%		The numerator is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) glucose or HbA1c; and (4) a lipid panel. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or at another facility for which records are available to the reporting facility. The denominator includes IPF patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period. The measure excludes patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical or psychological condition and patients with a length of stay equal to or greater than 365 days or equal to or less than 3 days. Screening for Metabolic Disorders Studies show that antipsychotics increase the risk of metabolic syndrome.1 Metabolic syndrome is a cluster of conditions that occur together, including excess body fat around the waist, high blood sugar, high cholesterol, and high blood pressure, all of which increase the risk of coronary artery disease, stroke, and type 2 diabetes.	**CMS/TJC**	**monthly meeting/ email to MHAS team**	**Virtusa CareDiscovery Quality Measures**
RESTRAINTS AND SECLUSIONS									
HBIPS-2* Hours of Physical Restraint Use (per 1000 patient hours) (lower = better) **FINALIZED** Data Source : Virtusa Latest Data Month: December 2023 *Event measures are calculated by event occurrence date	0.0006	0.0003	0.0002	0.0001		Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	**TJC**	**quarterly meeting/email to BHS team**	**Virtusa CareDiscovery Quality Measures**
HBIPS-3* Hours of Seclusion Use (per 1000 patient hours) (lower = better) **FINALIZED** Data Source : Virtusa Latest Data Month: December 2023 *Event measures are calculated by event occurrence date	0.0001	0.0002	0.0002	0.0003		Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	**TJC**	**quarterly meeting/email to BHS team**	**Virtusa CareDiscovery Quality Measures**

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: Cheryl Reinking, DNP, RN, NEA-BC, DipACLM
Date: May 6, 2024
Subject: Patient Experience feedback via patient letter to staff person

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's family who chose to write a letter to the hospital regarding the environmental services cleaning expert who made the patient's stay unforgettable.

2. Authority: To provide insight into one patient's experience with the environmental services personnel.

3. Background: This patient's family provided this feedback in praise of an EVS worker. These staff don't always get recognized because they don't provide clinical direct patient care. However, their work is just as important providing a safe and clean environment for our patients and families while providing encouraging words.

4. Assessment: This feedback has been shared with the staff member and she was highlighted at the daily huddle for all to recognize the difference she made in this patient and families visit to ECH. Everyone contributes to the patient's experience and this is an example of how every single employee that comes in contact with our patients and families can make a difference by giving reassuring and encouraging words.

5. Other Reviews: None

6. Outcomes: We continue to train all staff on WeCare standards and EVS has done an exceptional job in training all their staff as evidenced by this letter.

List of Attachments:

1. See patient comments.

Suggested Committee Discussion Questions:

1. How do you highlight the work of the EVS staff at ECH ?

2. How do you train all staff on the WeCare standards?

Febmany 2024

Dear Maria.

Thank you for sharing your bright spirit and joy with every day while she's been in the hospital. She had so much joy and always felt so uplifted by you when you cheerfully chatted with her while you took care of her room. We are so grateful for all your encouragement during this difficult time. You made our expenence so much better, you truly made a difference! Thank you!

Sincerely,

family

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: Ute Burness, RN, VP of Quality
Jaideep Iyengar, MD, Co-Chair, ECHMN Quality Committee
Date: May 6, 2024
Subject: ECHMN Quarterly Quality Report

Purpose:

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

Summary:

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

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

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

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

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

ECHMN has established true north pillars, one of which is quality and service. 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 March 31, 2024, the Network is on target for 3 of the measures. The key areas of focus on are on controlling blood pressure and the Hba1c metric. The attached slide deck describes the improvement plan that is in place.

For the dependable and convenient domain, third next available (3NA) remains unfavorable for primary care and specialty care. The clinical response to patient messages is slightly above target. The attached slide deck describes the improvement plan that is in place.

Likelihood to Recommend (LTR) is on target for ECHMN all, Specialty and Urgent Care. The PCP LTR score is below target. The attached slide deck describes the action plan that is in place.

List of Attachments:

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

Suggested Committee Discussion Questions:

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

El Camino Health

ECH Quality Committee Meeting
ECHMN Quality Update

May 6, 2024

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

Agenda

- **Clinical Domain**
  - Calendar Year 2024 First Quarter Results

- **Dependable and Convenient Domain**
  - FY 2024 3rd Quarter Results

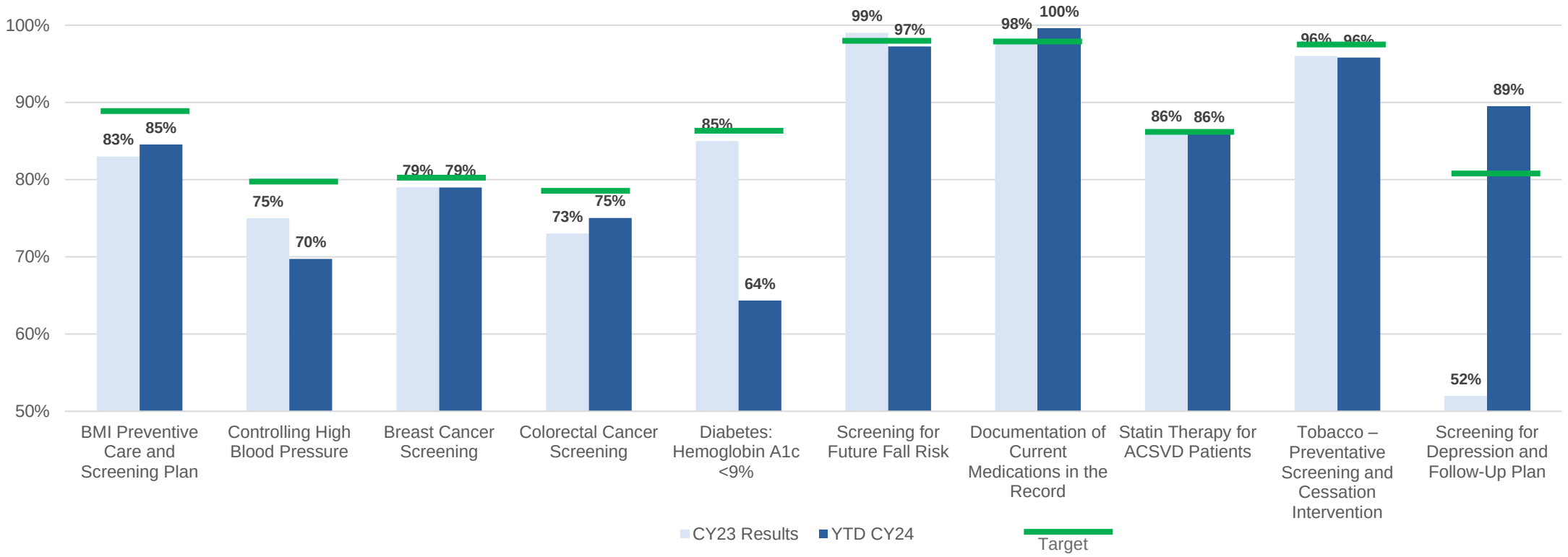
- **Patient Experience Domain**
  - FY 2024 3rd Quarter Results

Clinical Domain

CY 2024- Core Quality Measures Results through 3/31/24

Core Quality Measures	CY 2023 Results	CY 2024 Target	CY24 Results as of 3/31/24	Comments
CMS 112-Breast Cancer Screening	79%	82%	79%	On trend to meet target
CMS 122-Diabetes: Hemoglobin A1c <9%	85%	86%	64%	On trend to meet target
CMS 130-Colorectal Cancer Screening	73%	78%	75%	On trend to meet target
CMS 138-Tobacco – Preventative Screening and Cessation Intervention	96%	98%	96%	On trend to meet target
CMS 139- Screening for Future Fall Risk	99%	98%	97%	On trend to meet target
CMS 165-Controlling High Blood Pressure	75%	80%	70%	Hotspot- identified action plans in place
CMS 347-Statin Therapy for ACSVD Patients	86%	86%	86%	On target
CMS 68-Documentation of Current Medications in the Record	98%	98%	100%	On target
CMS 2-Screening for Depression and Follow-Up Plan	52%	80%	89%	On target
CMS 69- BMI Preventive Care and Screening Plan	83%	88%	85%	On trend to meet target

CY24 Overall Performance Versus Targets thru 3/31/24



Clinical Domain – Corrective Action Plan

Measure	Results	Contributing Factors	Action Plan
Controlling High Blood Pressure		• Low completion rates of taking a second blood pressure at the specialty and urgent care clinics. • Home monitoring information for patients is lacking. • Lack of standardized approach for treating hypertension.	• Development and implementation of best practice advisory (BPA) in EPIC, so specialist and urgent care providers can refer the patient back to their PCP. • Development and implementation of home monitoring materials for patients. • Development and implementation of standardized hypertension protocols. • Education for support staff about the importance of completing the second blood pressure check. • Managers to review their blood pressure remeasurement report to assess the completion rate for the Specialist and Urgent care. • Develop and implement a patient education document that Specialist and Urgent care providers can give to the patients.

Dependable and Convenient Care Domain

Dependable, Convenient and Experience Domain – FY 2024

Results as of March 31, 2024

Domain	Measure	Baseline FY23	FY24 Target	FYTD 24
Dependable and Convenient	Access 3na for Primary Care by Department (in days) (Access Third Next Available – Lower is better)	7.5	7.0	8.9
	Access 3na for Specialty Care by Provider (in days) (Access Third Next Available – Lower is better)	23.6	22	32.8
	Clinician Response to Patient Messages < 48 hours (in days)	1.6	1.2	1.5
Experience	Primary Care and Specialty LTR (Likelihood to Recommend)	80.7	81.3	82.1
	Urgent Care LTR (Likelihood to Recommend)	76.1	78.0	79.5

Met Target
Missed Target by < 5%
Missed Target by > 5%

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Dependable, Convenient Domain – Corrective Action Plan

Measure	Results	Contributing Factors	Action Plan
Primary Care 3rd Next Available (3NA)	8.9 Days	• Efforts to increase access has increased provider slot utilization. Because of the inverse relationship between slot utilization (2 weeks out) and 3NA, will likely continue to reflect unfavorable 3NA metrics. • Addition of new providers will ultimately improve access, however, lower of visits during the first few months of on-boarding doesn't reflect the future capacity for appointments. • Limiting physicians to 3 long appointments for each session may be contributing to higher 3NA.	• An easy solution is to keep one open slots for each provider each day. This improves 3NA, but may not improve access if the slot is not filled the same day. This approach is under consideration. • Have recruited additional RNs to help physicians to see higher number of patients. • Continue to recruit PCP's and APCs through December 2024. • Monitor physician schedules for maximum physician capacity. • Use APCs to offload certain appointments from highly demanded physicians. • Expected to reduce 3NA by June 2024.
Specialty Care 3rd Next Available (3NA)	32.8 Days	• Insufficient number of specialist within the medical group. • Inability to measure access within the IPA – current access is not true representation if patients are referred to community physicians fully aligned with ECH.	• Continue to recruit specialists and APCs • Develop Epic referral guidelines through July 2024 • Organize referral directory by tiering of specialists in Epic – September 2024 • Move from 3NA measurement to Time to Consult by End of Fiscal year • Specialty access should have gradual improvement over next 12 months
Clinician Response Time for Messages	1.5 Days	• Refill request Epic workflow inflates the average turnaround time	• Refill request workflow is being changed and provider education has already started. • Expected to meet target by June 2024

Patient Experience Domain

Patient Experience Domain – Results FY2024

ENTERPRISE	FY23 (Baseline)	FY24 Target Goals	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 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**	**82.1**	**1.4**	**0.8**
Primary Care & Specialty Care	27	32	34	35	21	37	32	38	33	25	28		
	10017	-	1286	826	703	697	546	458	576	619	5711		
ECHMN - Primary Care	**79.6**	**80.1**	**80.6**	**81.6**	**77.6**	**81.3**	**77.4**	**77.7**	**81.8**	**79.4**	**79.9**	**0.3**	**-0.2**
with Pediatrics	22	26	26	30	15	28	14	14	27	17	18		
	5720	-	612	396	304	336	292	238	280	339	2797		
ECHMN - Specialty Care	**82.2**	**82.6**	**83.7**	**83.3**	**80.7**	**84.5**	**88.2**	**89.6**	**83.8**	**84.3**	**84.2**	**2.0**	**1.6**
	34	39	44	43	26	47	77	88	39	42	41		
	4297	-	674	430	399	361	254	220	296	280	2914		
ECHMN - Urgent Care	**76.1**	**78.0**	**77.2**	**77.6**	**73.8**	**80.0**	**83.3**	**77.5**	**81.6**	**82.1**	**79.5**	**3.4**	**1.5**
	36	68	36	37	19	53	74	48	72	79	68		
	1323	-	158	156	107	140	162	178	228	184	1313		
All Clinics LTR Clinic Top Box e-survey adjusted - Indicates Incentive Goal*													

Analysis by Area & Question

FYTD % of Distribution of Responses for Medical Practice Survey *FYTD = 7/1/23-2/29/24*			
Questions	Very Poor, Poor, & Fair%	Good & Very Good%	Nat'l Fac Rank
Ease of scheduling appointments	6.4	93.6	26
Courtesy of registration staff	2.8	97.2	27
Likelihood of recommending	4.9	95.1	28
Ease of contacting	8.4	91.6	29
Likelihood of recommending CP	4.5	95.5	29
CP efforts to include in decisions	3.9	96.1	31
Time CP spent with patient	4.7	95.3	31
How well staff protect safety	2.8	97.2	32
Our concern for patients' privacy	2.6	97.4	34
CP discuss treatments	4.5	95.6	35
CP concern for questions/worries	3.3	96.7	36
Staff worked together care for you	3.4	96.6	36
Wait time at clinic	9.2	90.9	38
CP explanations of prob/condition	3.8	96.2	38
How well nurse/asst listen	2.3	97.7	40
Ability to get desired appointment	9.6	90.4	48
Concern of nurse/asst for problem	3.1	96.9	49
Information about delays	8.1	91.9	63

Site	FY23 BASELINE	FY24 LTR Clinic TARGET	FYTD	Point Change to Target	Nat'l Fac Rank	Bay Area Rank	Weight
PRIMARY CARE							
ALL PRIMARY CARE	79.6	80.1	79.9	-0.2	18	22	YTD
*Cedar Pavilion**	-	-	71.4	n/a	5	7	1.0%
First Street Clinic*	80.0	80.6	71.4	-9.1	5	7	1.0%
McKee Clinic	76.5	77.8	80.2	2.5	20	22	16.1%
Morgan Hill Clinic	81.0	81.5	85.0	3.5	47	45	17.4%
Samaritan Clinic	76.5	77.7	76.3	-1.5	11	13	17.2%
Sobrato Pavilion	73.9	75.1	74.3	-0.8	9	11	10.3%
Willow Glen Clinic	82.8	83.3	81.4	-1.9	25	26	18.8%
Winchester Clinic	83.8	83.9	80.5	-3.4	21	23	18.2%

Site	FY23 BASELINE	FY24 LTR Clinic TARGET	FYTD	Point Change to Target	Nat'l Fac Rank	Bay Area Rank	Weight
ALL SPECIALTY CARE	82.2	82.6	84.2	1.6	41	40	YTD
Bay Area Maternity	85.1	85.2	94.0	8.8	99	94	2.3%
*LG Cancer Clinic**	92.1	92.1	91.2	-0.9	94	83	2.0%
McKee Clinic	81.0	81.6	83.7	2.1	37	37	18.1%
MV Cancer Clinic	86.9	86.9	87.6	0.7	70	62	25.7%
*MV Women's Heart Center**	87.5	87.5	87.5	0.0	69	61	0.8%
Parr Clinic	82.9	83.3	80.9	-2.4	23	26	9.7%
Samaritan Clinic	80.3	80.9	80.4	-0.5	20	23	7.0%
Sobrato Pavilion	81.9	82.3	81.5	-0.8	25	27	8.3%
Willow Glen Clinic	82.3	82.7	81.9	-0.8	27	29	23.5%
					96	89	2.7%

Site	FY23 BASELINE	FY24 LTR Clinic TARGET	FYTD	Point Change to Target	Nat'l Fac Rank	Bay Area Rank	Weight
URGENT CARE							
ALL URGENT CARE	76.1	78.0	79.5	1.5	67	73	YTD
Cupertino Urgent Care	71.7	74.1	84.0	9.9	88	89	19.0%
First Street Urgent Care	74.6	77.0	78.1	1.1	58	69	9.7%
Mountain View Urgent Care	73.8	76.2	76.2	0.0	48	62	22.7%
Willow Glen Urgent Care	78.7	81.1	79.6	-1.5	68	73	48.5%

Action plan by question and Clinic

El Camino Health

Patient Experience – Corrective Action Plan

Measure	Results	Contributing Factors	Action Plan
Primary Care LTR	**Below Target**	• New patients to a provider must have an establish care visit (long appointment) before they are able to schedule physical exam with a provider • Too many long appointment visit types delaying new patient access (establish care, AWV, physical exam, etc.) • Only 3 long appts in AM, and 3 long appts in PM • Call Center following strict scheduling rules must forward messages to clinic (increasing # of messages created & causing friction before scheduled appointment time, e.g., ease of contact, courtesy of reg staff, etc.), but rules can be broken by clinic • Delayed new patient appointments lead to increased no shows & late cancellations as they have likely sought care elsewhere • Providers have unique scheduling rules (private/same day slots, etc.)	• Access/template workshop planned

Questions?

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: Lyn Garrett, MHA, MS, CPHQ, Senior Quality Director
Date: May 6, 2024
Subject: Enterprise Quality, Safety and Experience and STEEEP Dashboards through March 2024

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety, and experience measure performance through March 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 March (0.904) and Fiscal Year-To-Date (1.158) we are favorable to target of (1.201).

   a. **C. Difficile Infection:** The C. Diff rate per patient days x 10,000 (0.680) for the third quarter and year to date (0.784) are favorable to target (0.805). There have been 25 hospital acquired infections in FY24. For the month of February, we had zero hospital on-set C. Diff cases. 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. (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 Q3 (0.058) 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 through March 2024. There were zero CAUTI's enterprise wide in January and March 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 third 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 third quarter (0.147) and year to date (0.077) 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 Q3 nvHAP rate (0.080) improved from Q1 (0.125) and is at target (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. There was one nvHAP in the month of March 2024. 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 are currently meeting our targets and focused on maintaining)

2. **Surgical Site Infection**. The rate of surgical site infections for FY24 Q3 (0.551) is unfavorable to target (0.369). Process improvement has included staff education on hand hygiene, surgical attire, and sterile equipment processing. These initiatives have decreased surgical site infections for TKR surgeries. The OR departments are continuing their work on vendor behavior and reducing traffic and door opening during orthopedic joint replacement surgical procedures. There have been 4 whipple (pancreatic cancer surgery) surgical site infections this year. More than in previous years. We are partnering with Dr. Singhal to explore providing nutrition supplementation for 5 days prior to their scheduled surgery. Patients with pancreatic cancer have poor nutritional status, and diabetes due to the cancer affecting insulin production. So, these patients are at very high risk of surgical site infection. (Timeline for improvement: We are considering adjusting the target for SSI as the complexity and volume of surgeries being performed have increased significantly in the past two years. We will collaborate with the surgery medical executive

committee and infection prevention to ensure our target is meaningful and achievable)

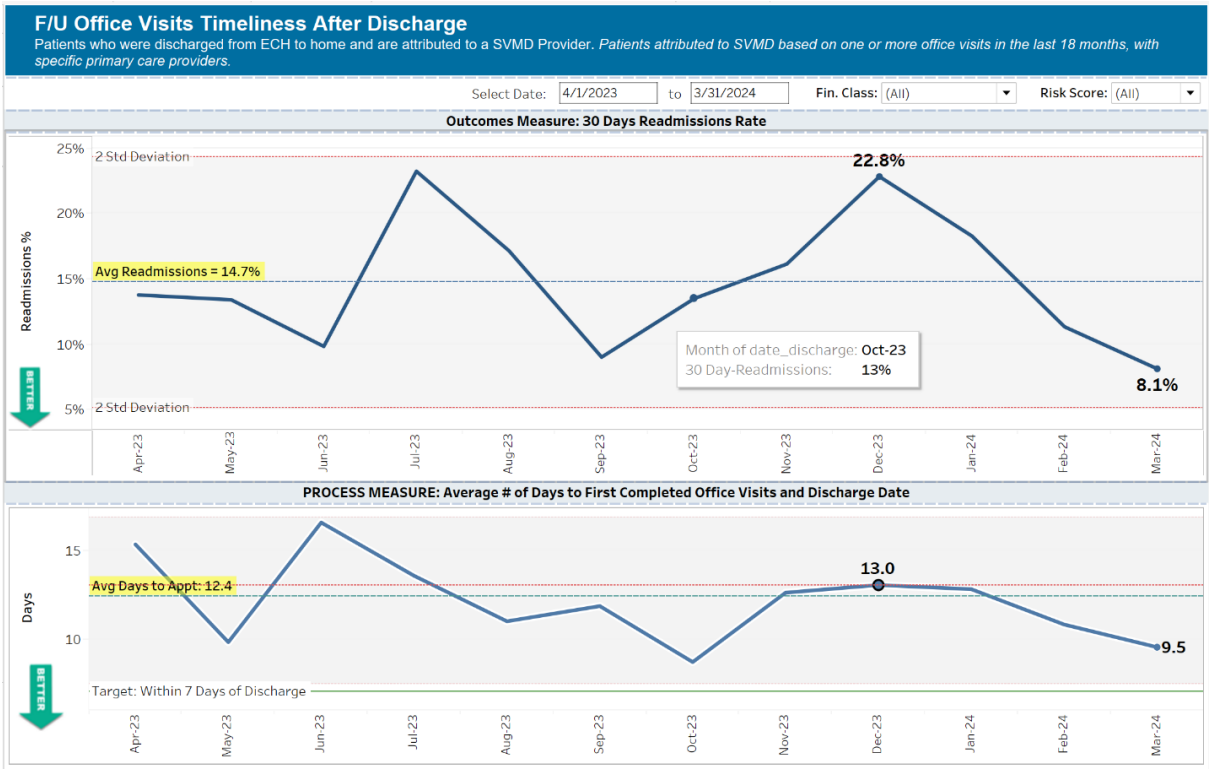
B. Timely

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 Q3 FY24 (88.7%) is unfavorable to target but improved from prior quarters. Performance in January (91.0) and February (90.6) exceeded target. Issues Surrounding Chem Line (DxA) OR Analytical Instrument (DxI): On March 3, 2024, we identified that certain specimens were resulting in erroneously high troponin values. To mitigate risk on patient impact, we immediately implemented a manual repeat process until we were able to identify the root cause of inaccurate results. Repeats of erroneously high results generally gave a lower and more accurate result. We were able to catch erroneous results this way. Each analysis can take up to 45mins; a repeat would incur an additional 45mins to the TAT. Specimens run for Troponin should be fully clotted specimens. We found that specimens were not fully clotting before they were being run on the analyzer. The micro clots were causing falsely increased results. On April 2, 2024, we discontinued the repeat process. Our new process still requires extra manipulation, but it is less impactful on the TAT. High Troponin Values will also bring one DXI down for TROHS testing temporarily as we must replace the reagent and re-QC the instrument. This has not yet been resolved by the manufacturer. Critical Calls for high values continue to impact TAT; we are waiting for approval from HVI on the new critical call threshold. In summary, actions being taken: Daily monitoring of chemistry TAT. Continuation of weekly meetings with Beckman to address concerns with line/instrumentation. They've also scheduled a meeting with us in Feb to address possibilities for process improvement. Updating our Critical Call Threshold. (Timeline for improvement: We met/exceeded target in January and February. We are focused on sustaining the improvements deployed in these months to achieve target in Q4)
2. **Imaging Turnaround Time: ED including X Ray (target + % completed <= 45 minutes).** Performance for Q3 (81.4%) and YTD (78.4%) are unfavorable to target (84%). FY 24 Q3 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: Within 3-months of this transition, we anticipate a significant improvement (decrease) in reading times)

C. Effective

1. Risk Adjusted Readmission Index. Performance through February 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. Recent data on "F/U Office Visits Timeliness After Discharge" indicates a significant improvement, with the readmission rate decreasing to 8.1% in March from over 22% in December. Additionally, the average time to the first completed appointment after discharge has decreased from 13 days to 9 days in March,

correlating well with the decrease in readmissions. This improvement underscores the benefits of an integrated approach, providing a smooth transition between inpatient and ambulatory care for our patients who seek care at ECH.



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”)

2. Risk Adjusted Mortality Index. Performance for FY24Q3 (1.09) and YTD (1.08) 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 FY24Q3 (1.17) and YTD (1.21) 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). The FY24Q2 performance of (22.7%) exceeding target of 23.9% was not sustained. FY24Q3 performance (28.3%) 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 (1.20) is unfavorable to target (1.15). A formidable challenge to decreasing length of stay for patients whose discharge disposition is a skilled nursing facility (SNF) are the barriers payors have in place to authorize timely discharge to a SNF. Our teams 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 will expand to the nursing unit on 3C. This expansion aims to replicate the positive outcomes observed in the initial phase, optimizing patient care and efficiency in discharging patients.

- 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 will not achieve target for YTD due to the 1.24 LOS in the third quarter. Successful spread of the multidisciplinary rounding will be a key factor in achieving target by Q3 of FY25, if not sooner)

2. **Median Time from ED Arrival to ED Departure (Enterprise).** The current FY24Q3 performance (152 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 Q3 of FY24, documentation indicating that weather-appropriate clothing was provided to homeless patients prior to discharge improved from 64.9% to 73.1% (FYTD 62.8%). 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 third quarter of FY2024 eleven of eleven 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 March (81.8) and FY24YTD (81.4) 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. For our Mountain View Campus, we saw substantial increases in 3C and 4A unites (green after four months of red) and a noticeable increase in our LG Med Surg Unit. 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 the month of March (88.6) and FY24YTD (82.2) performance exceeded target of 75. Our Mother/Baby units exceeded their enterprise targets for the month of March on both campuses with Los Gatos achieving a **top box score of 100.0!** 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 did not achieve target (71.7) for the month of March (70.7), however, as an enterprise, (75.5) we are exceeding target 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 did not achieve their target (81.3) for the month of March (80.8). Year to date (82), ECHMN is exceeding target. We did exceed our target in the areas of Specialty Care and Urgent Care, but not in primary care. We continue to work with our primary care clinics on access and scheduling (the organization is recruiting as fast as they can!). Also, during the month of March was the welcoming of the new USNC (Urology) clinics and our staff spent a lot of time partnering with USNC to provide patient experience focused onboarding.

Attachments:

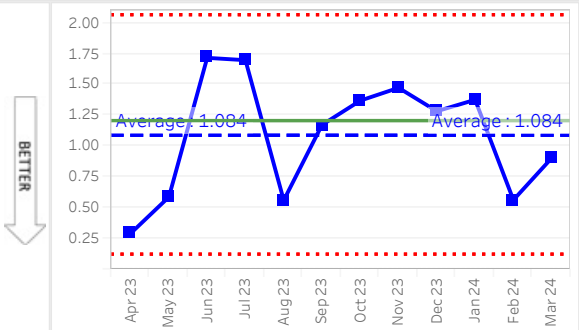
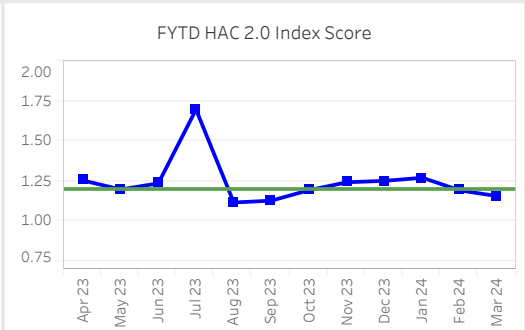
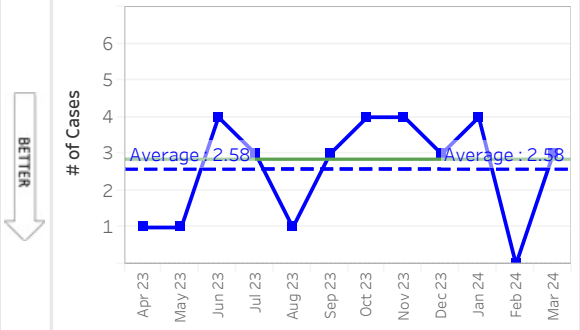
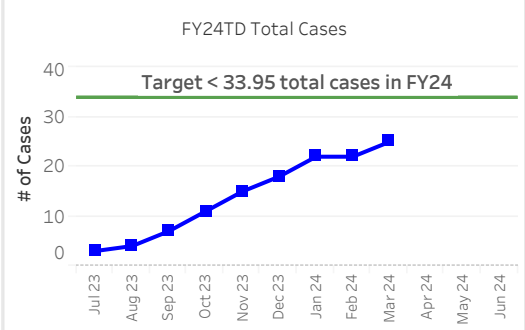
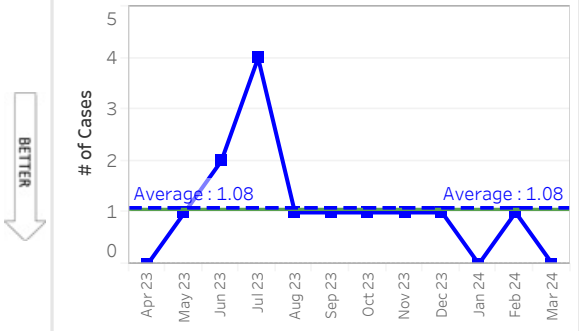
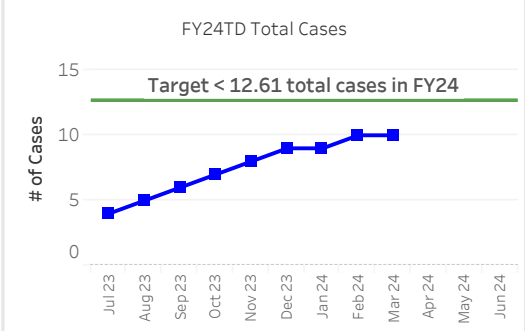
1. Enterprise Quality Dashboard through March 2024
2. STEEEP Dashboard through Q3 of FY2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

March 2024 (unless other specified)

Month to Board Quality Committee : May 2024

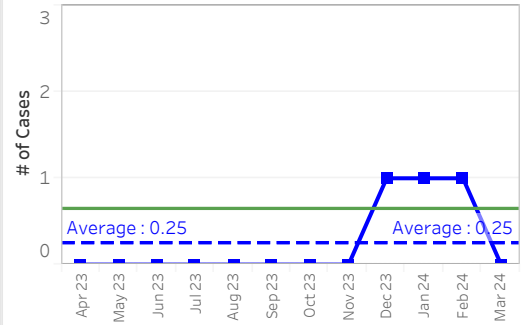
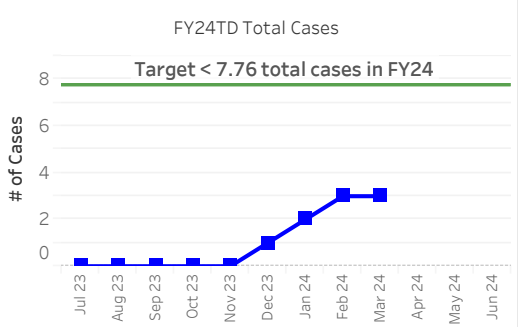
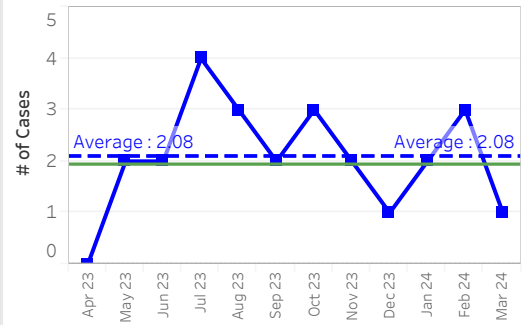
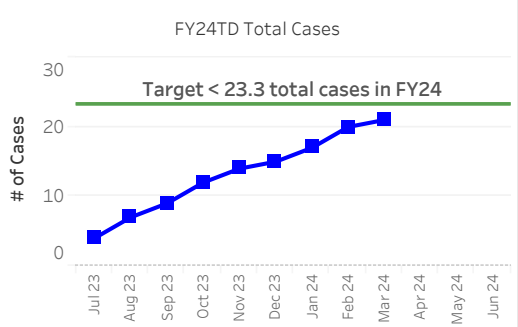
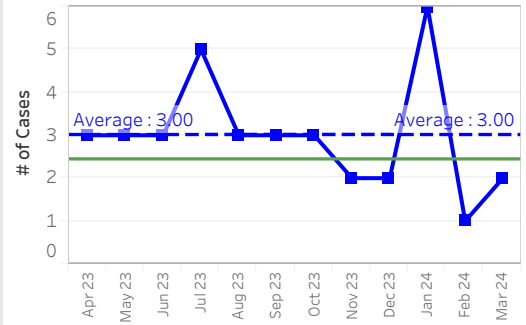
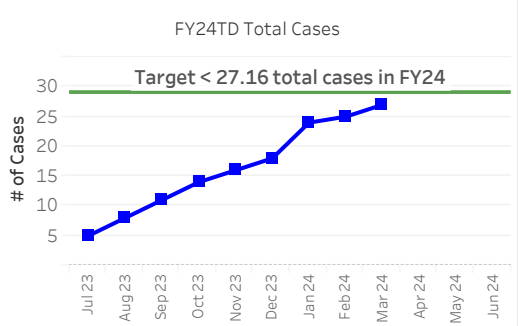
Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal HAC Index 2.0 Latest Month : March 2024	0.9044	1.158	1.238	1.201 (3.0% ↓)		
HAC Component Clostridium Difficile Infections (C-Diff) Latest Month : March 2024	3 cases	2.78 cases/mo	2.92 cases/mo	2.83 cases/mo		
HAC Component Catheter Associated Urinary Tract Infection (CAUTI) Latest Month : March 2024	0 cases	1.11 cases/mo	1.08 cases/mo	1.05 cases/mo		

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

March 2024 (unless other specified)

Month to Board Quality Committee : May 2024

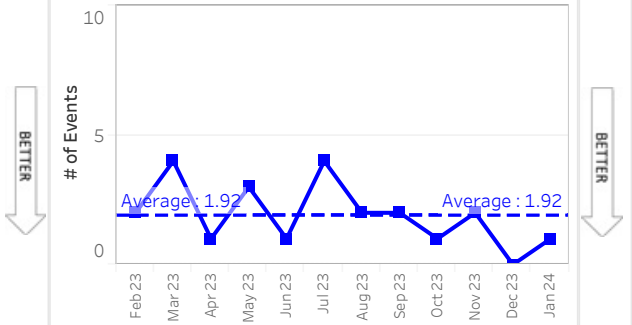
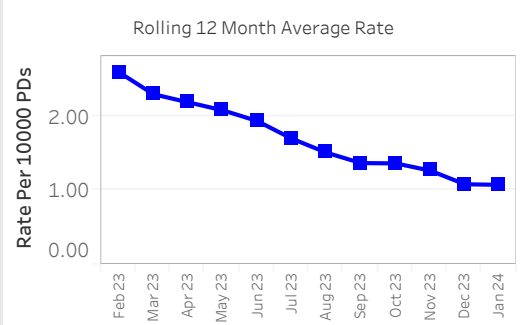
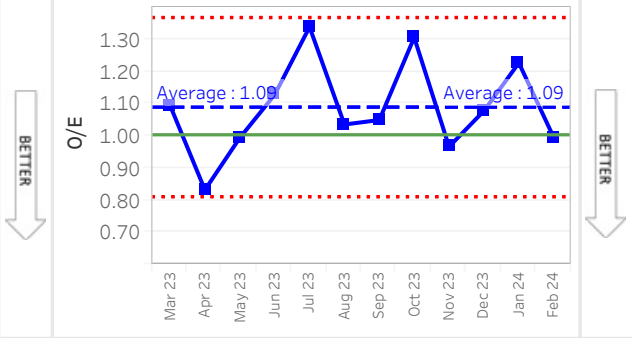
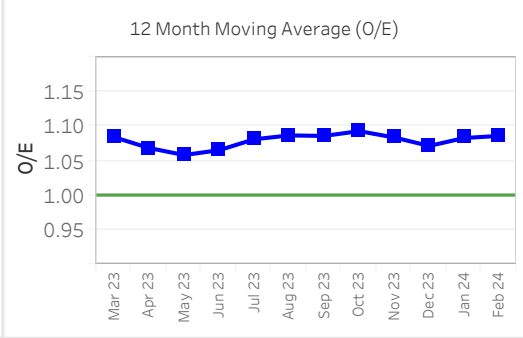
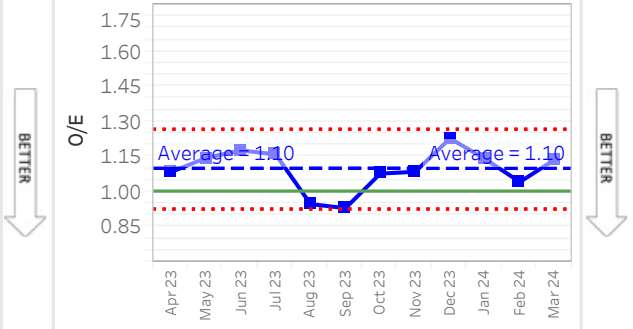
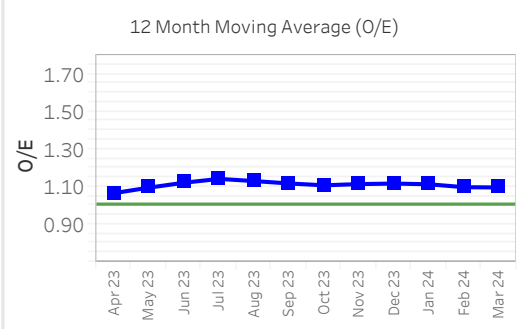
Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
HAC Component Central Line Associated Blood Stream Infection (CLABSI) Latest Month : March 2024	0 cases	0.33 cases/mo	0.67 cases/mo	0.65 cases/mo		
HAC Component non-ventilator Hospital-Acquired Pneumonia (nvHAP) Latest Month : March 2024	1 cases	2.33 cases/mo	2.00 cases/mo	1.94 cases/mo		
Surgical Site Infections (SSI) Latest Month : March 2024	2 cases	3.00 cases/mo	2.50 cases/mo	2.42 cases/mo		

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

March 2024 (unless other specified)

Month to Board Quality Committee : May 2024

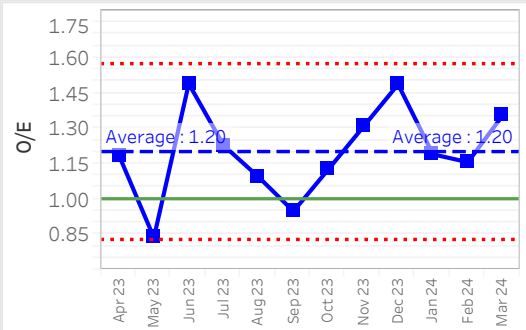
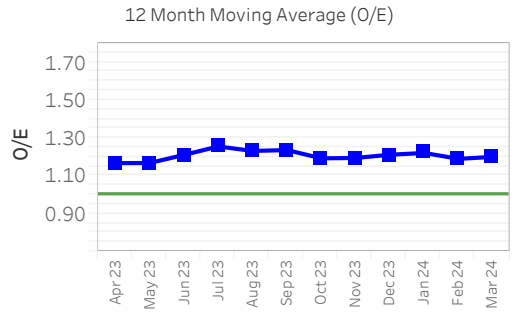
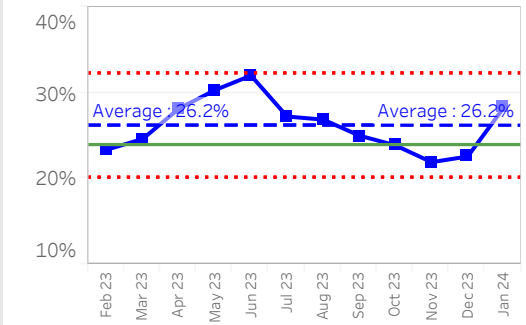
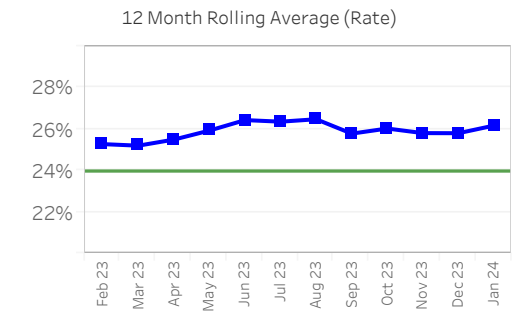
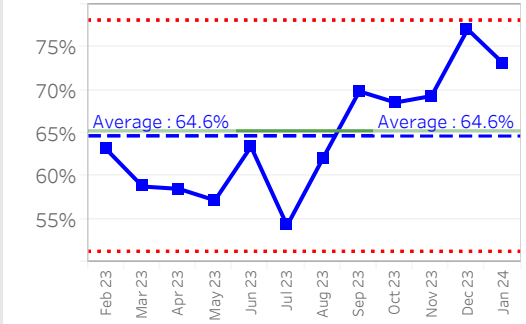
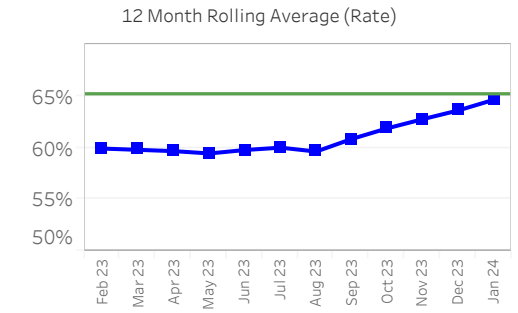
Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Serious Safety Event Rate (SSER) Latest Month : January 2024	1 events	0.96 (12 / 125235)	1.93 (41 / 212460)	n/a		
Readmission Index (All Patient All Cause Readmit) Observed / Expected Premier Care Sciences Standard RA Latest Month : February 2024	0.99 (8.29% / 8.33%)	1.13 (9.03% / 8.03%)	1.07 (8.47% / 7.94%)	1.00		
Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : March 2024	1.14 (2.11% / 1.86%)	1.08 (2.12% / 1.96%)	1.13 (2.21% / 1.96%)	1.00		

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

March 2024 (unless other specified)

Month to Board Quality Committee : May 2024

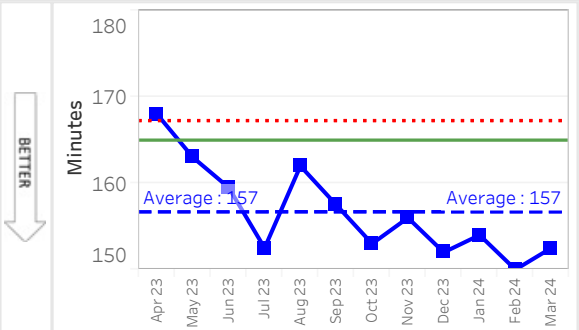
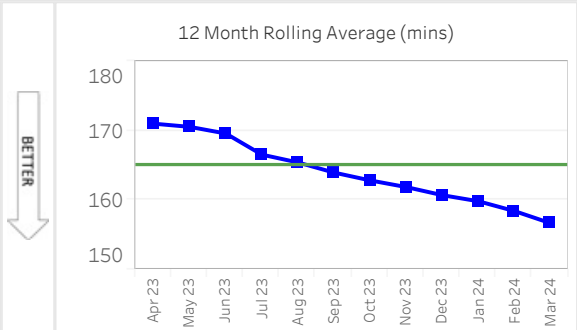
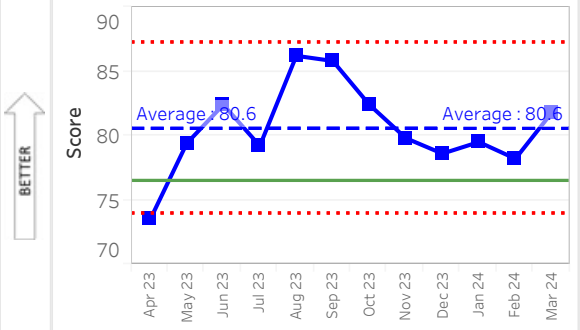
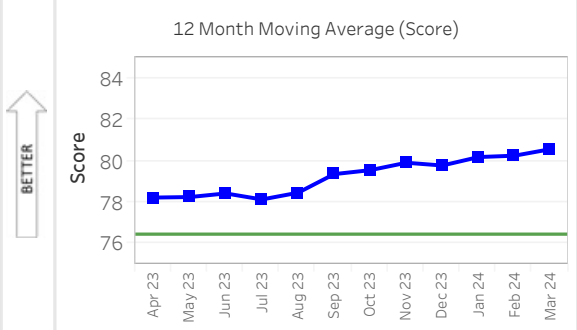
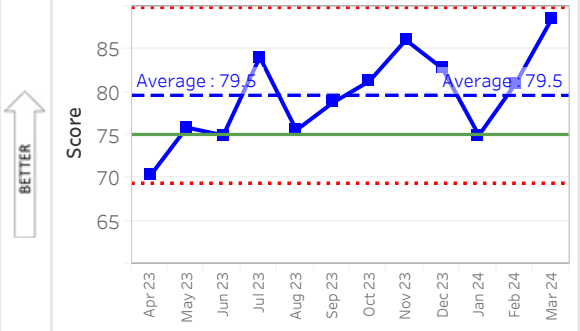
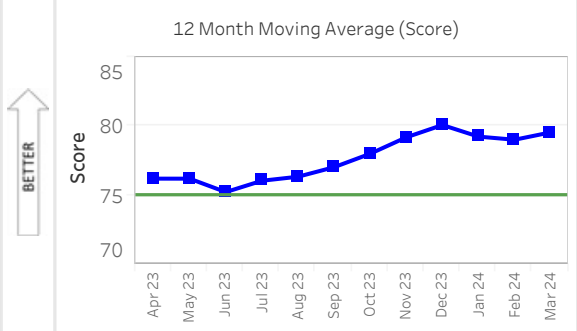
Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Sepsis Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : March 2024	1.35 (13.11% / 9.68%)	1.21 (14.00% / 11.56%)	1.21 (14.07% / 11.59%)	1.00		
PC-02 : Cesarean Birth Latest Month : January 2024	MV : 28.7% (47 / 164)	MV : 25.9% (298 / 1152)	MV : 27.6% (516 / 1869)	23.9% (FY24 ENT Target)		
	LG : 25.0% (5 / 20)	LG : 19.4% (30 / 155)	LG : 19.4% (62 / 320)			
	ENT : 28.3% (52 / 184)	ENT : 25.1% (328 / 1307)	ENT : 26.4% (578 / 2189)			
PC-05 : Exclusive Breast Milk Feeding Latest Month : January 2024	MV : 72.6% (207 / 285)	MV : 68.7% (1442 / 2099)	MV : 58.1% (1966 / 3385)	65.1% (FY24 ENT & MV Target) 70.0% (FY24 LG Target)		
	LG : 76.2% (32 / 42)	LG : 83.0% (249 / 300)	LG : 68.3% (427 / 625)			
	ENT : 73.1% (239 / 327)	ENT : 67.7% (1612 / 2380)	ENT : 59.7% (2393 / 4010)			

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

March 2024 (unless other specified)

Month to Board Quality Committee : May 2024

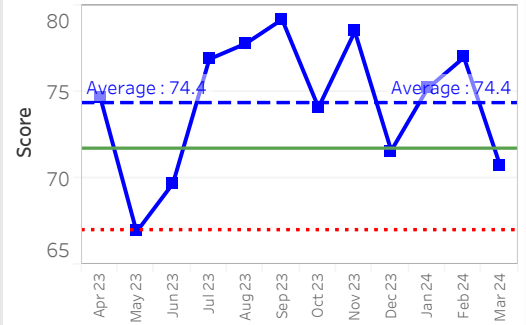
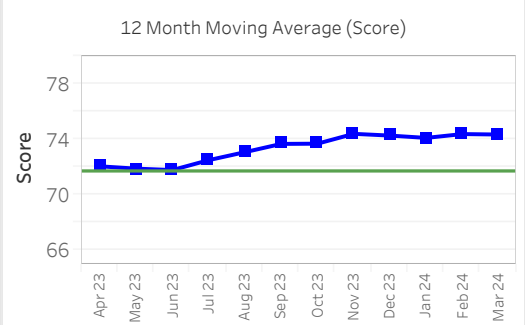
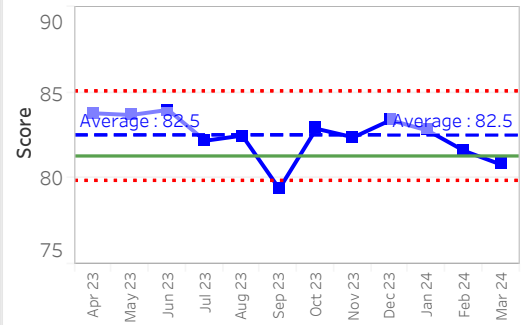
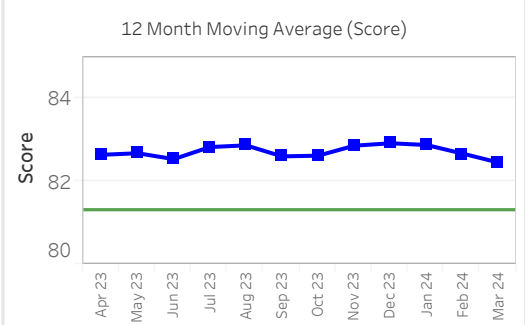
Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise) Latest Month : March 2024	MV : 172 mins LG : 133 mins ENT : 153 mins	MV : 175 mins LG : 134 mins ENT : 155 mins	MV : 194 mins LG : 142 mins ENT : 168 mins	MV : 191 mins LG : 139 mins ENT : 165 mins		
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : March 2024	81.8	81.4	78.5	76.4		
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : March 2024	88.6	82.2	75.0	75.0		

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

March 2024 (unless other specified)

Month to Board Quality Committee : May 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : March 2024	70.7	75.5	71.7	71.7		
*Organizational Goal ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : March 2024	80.8	82.0	82.7	81.3		

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

March 2024 (unless other specified)

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

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

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

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

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

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

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 December 2023
2.) Readmissions through January 2024
3.) PC-02 & PC-05 through December 2023
4.) Updated as of 2024-03-19

Month to Quality Committee of the Board: May, 2024

El Camino Health

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**

El Camino Health

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'

El Camino Health

Quality Committee Meetings
FY2025 Dates

QUALITY COMMITTEE DATES MONDAYS
Monday, August 5, 2024
Tuesday, September 3, 2024 *Moved due to the Holiday
Monday, November 4, 2024
Monday, December 2, 2024
Monday, February 3, 2025
Monday, March 3, 2025
Monday, May 5, 2025
Monday, June 2, 2025

El Camino Health

FY25 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: **Holly Beeman, MD, MBA,** Chief Quality Officer (Executive Sponsor)

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

GOALS	TIMELINE	METRICS
1. Ensure the metrics included on the Quality Committee dashboards are in alignment with the El Camino Hospital Board strategic plan.	Q4FY24 review and update which measures to include on the FY25 Quality Dashboards.	Quality and experience performance measures aligned with the STEEEP domains of; safe, timely, effective, efficient, equitable, and person-centered.
2. Monitor Quality, Patient Care, and Patient Experience performance in accordance with the pacing plan to track progress towards achieving targets.	Q4FY24 review FY25 Incentive Goal recommendations for Quality, Safety, and Patient Experience pillars.	Performance measures on the Quality Dashboards. ▪ Monthly Quality Dashboard ▪ Quarterly Board Level Quality Dashboard
3. Identify and reduce health care disparities for ECH patients.	Biannual report to Quality Committee FY25.	Monitor the effectiveness of ECH activities to reduce healthcare disparities through review of the biannual "health equity report".
4. Foster a culture of collaboration, transparency, and continuous improvement within the Quality Committee.	Fiscal Year 2025	• Attend a minimum of 6 meetings in person. • Actively participate in discussions at each meeting. • Review of annual committee self-assessment results as facilitated by the Director of Governance.
5. Committee members participate in ongoing training and development to deepen their knowledge of quality, patient care, and patient experience topics.	Fiscal Year 2025	Attend a conference and/or session with a subject matter expert. • Verbal/Written report of key learnings to the Quality Committee.

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

El Camino Health

APPROVED BY QC
XX/XX/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												✓
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)

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Lyn Garrett, MHA, MS, CPHQ, Senior Quality Director
Date: May 6, 2024
Subject: El Camino Health Quality Improvement and Patient Safety Plan (QAPI) for 2024

Recommendation: Approve Quality Assessment and Performance Improvement Plan (QAPI)

Authority: The Board Quality, Patient Care and Patient Experience Committee is responsible for the oversight of the QAPI program through its periodic review of the program, including, the development of a plan to implement and maintain the QAPI program, the review of the progress of QAPI projects, the determination of annual QAPI projects, and the evaluation of the effectiveness of improvement actions that the hospital has implemented. *(Department of Health and Human Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, March 9, 2023)*

Background: The Centers for Medicare and Medicaid Services (CMS) requires hospitals to have a well-designed and well-maintained QAPI program as a condition of participation. CMS requires that a hospital's QAPI program "provides a process by which a hospital can fully examine the quality of care it delivers and implement specific improvement activities and projects on an ongoing basis for all of the services provided by the hospital, while considering the scope and complexity of those services and the patient populations it serves." *(Department of Health and Human Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, March 9, 2023)*. The ECH QAPI program is updated annually to reflect, timely, the systems we have in place to identify and correct problematic events, policies or practices to ensure we are effective in improving performance, quality and safety.

Assessment: The El Camino Hospital QAPI plan describes our ability to develop, implement, and maintain an effective, ongoing, hospital-wide, and data-driven quality assessment and performance improvement program, which also includes tracking and monitoring of adverse events and medical errors. A notable enhancement to our FY24 QAPI plan is a focused section (section II) on our Patient Safety Plan and Safety First Mission Zero efforts to eliminate preventable harm.

Other Reviews: Reviewed and approved by the Quality Council, Patient and Employee Safety Committee and the Medical Executive Committee.

Outcome: The Committee will approve the QAPI Plan. There are no changes to the plan to report or review.

List of attachments:

1. Quality Assessment and Performance Improvement Plan with referenced QAPI addendums.

Status **Pending** PolicyStat ID **14285860**

Origination	05/2018	Owner	Michael Coston: Director Quality and Public Reporting
Last Approved	N/A		
Effective	Upon Approval	Area	Quality
Last Revised	11/2023	Document Types	Plan
Next Review	1 year after approval		

Quality Improvement & Patient Safety Plan (QIPS)

COPY

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

ORGANIZATION OVERVIEW

El Camino Hospital (ECH), doing business as El Camino Health, is a comprehensive health care institution that includes two hospital campuses; a 275-bed acute hospital with 36 acute psychiatric beds headquartered in Mountain View (MV), California and a 143-bed acute hospital in Los Gatos (LG), California. Both campuses have associated outpatient services and clinics. ECH in Mountain View has achieved Joint Commission certification as a Thrombectomy-capable Stroke Center, in Joint Replacement for Hip and Knee, Hip Fracture, for Sepsis and Patient Blood Management. The Los Gatos campus has been certified as a Primary Stroke Center, in Joint Replacement for Hip and Knee, Spinal Fusion and as a "baby friendly hospital" by WHO/ UNICEF.

The ECH Medical Staff includes 1100 active, telemedicine, provisional and consultant, 328 affiliate physicians, and 116 independent practitioners with representation covering nearly every clinical specialty (e.g., Anesthesiology, Cardiology, Emergency, Gastrointestinal, Family Practice, Neonatology, Obstetrics, Gynecology, Pediatrics, Pulmonary Medicine, Radiology, Ophthalmology, Orthopedics, Neurology, Endocrinology, Urology, General Surgery, Cardiovascular Surgery, Pediatrics, Pathology, Internal Medicine, and Neurosurgery. Performance Improvement activities are selected and prioritized based on the hospital's scope of service.

El CAMINO HEALTH MISSION

Our Mission is to heal, relieve suffering and advance wellness as your publicly accountable health partner.

El CAMINO HEALTH VISION

To provide consumers in the South Bay with a high quality, locally-oriented health system, across the full care continuum.

El CAMINO HOSPITAL VALUES

Quality: We pursue excellence to deliver evidence-based care in partnership with our patients and families.

Compassion: We care for each individual uniquely with kindness, respect and empathy.

Community: We partner with local organizations, volunteers and philanthropic community to provide healthcare services across all stages of life.

Collaboration: We partner for the best interests for our patients, their families and our community using a team approach.

Stewardship: We carefully manage our resources to sustain, grow and enable services that meet the health needs of our community.

Innovation: We embrace solutions and forward thinking approaches that lead to better health.

Accountability: We take responsibility for the impact of our actions has on the community and each other.

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DEFINITIONS:

El Camino Hospital has adopted the Institute of Medicine's (IOM) Quality Framework – STEEEP – as its definition of quality. These six aims for a healthcare system comprise ECH's approach to quality:

- **Safe:** Avoiding harm to patients from the care that is intended to help them
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Efficient:** Avoiding wastes, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

SERVICES/PROGRAMS

ECH provides a full continuum of inpatient and outpatient care including:

Acute Inpatient Services:	**Emergency Services**	**Outpatient Services**
Acute Rehabilitation	Basic Emergency	Advanced Care & Diagnostics Center
Cardiac Catheterization		Behavioral Services – Outpatient

Services		
Cardiovascular Surgery		Cancer Center
Intensive & Critical Care Unit		Cardio Pulmonary Wellness Center
Labor and Delivery (L&D)		Endoscopy
Medical/Surgical/Ortho		Infusion Services
Mental Health and Addiction Services (Inpatient Psychiatry)		Interventional Services
Mother/Baby		Occupational Therapy/Physical Therapy
Level II and Level III Neonatal Intensive Care Unit (NICU)		Outpatient Surgical Units
Operating Room (OR)		Pre-admission Service/ Pre-op/ Short Stay Unit (2B)
Ortho Pavilion		Radiation Oncology
Pediatrics		Radiology Services (Imaging, Interventional, Nuclear Medicine, Ultrasound, MRI, Breast Health Center, Mobile Imaging)
Post-Anesthesia Care Unit (PACU)		Rehabilitation
Progressive Care Unit (PCU) (Step-down)		Speech Therapy
Telemetry/Stroke		Wound Care Clinic

COPY

Section I Quality Improvement Plan

PURPOSE

The Quality Improvement Plan, as equivalent to CMS' Quality Assessment Performance Improvement (QAPI), describes the multidisciplinary, systematic quality improvement framework utilized by El Camino Hospital (ECH) to improve patient outcomes and reduce the risks associated with healthcare in a manner that embraces the mission of ECH.

OBJECTIVES

1. Provide safe, effective, patient centered, timely, efficient, and equitable care (STEEEP).
2. Establish and maintain an ongoing, comprehensive and objective mechanism to improve performance, clinical outcomes, and patient safety based on the complexity of the ECH's services/ programs.
3. Identify known, suspected or potential problems or hazards in patient care delivery, as well as opportunities for further improvement in currently acceptable care.
4. Establish priorities/goals for the investigation and resolution of concerns and problems by focusing on those with the greatest potential impact on patient care outcome, patient safety, and patient satisfaction.
5. Define corrective action and document resolution of known and potential problems and evidence of patient care improvement.

6. Communicate performance activities and findings to all pertinent Hospital and Administrative Staff, Medical Staff, and the Governing Board, as appropriate.
7. Identify continuing education needs of clinical, administrative, and support personnel relative to Quality and Patient Safety.
8. Coordinate Performance Improvement activities and findings with those of the facility's Management of the Environment, Surveillance, Prevention and Control of Infection, Information Management, Management of Human Resources, Ethics/Rights/Responsibilities, Provision of Care, Medication Management, and Leadership functions to the extent possible.
9. Monitor and comply with policies, standards, regulations and laws set by the Governing Board, Medical Staff, The Joint Commission, State and Federal governments and other regulating or accrediting bodies.
10. Enhance uniform performance of patient care processes throughout the organization, reducing variability.
11. Provide a mechanism for integration of quality improvement activities throughout the hospital for colleagues, medical staff, leadership, volunteers and governance.
12. Respond to external hospital environment or community needs in regards of providing equitable care and positive quality outcomes.

ACCOUNTABILITY FOR QUALITY, PERFORMANCE IMPROVEMENT

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Governing Board

As described in the Governing Board Rules and Regulations, the Governing Board of El Camino Health bears ultimate responsibility for the quality and safety of patient care services provided by its medical, other professional and support staff. The Governing Board shall ensure an ongoing, comprehensive and objective mechanism is in place to monitor and evaluate performance, to identify and resolve documented or potential problems/hazards, and to identify further opportunities to improve patient care and safety. As appropriate, the Board shall delegate responsibility and oversight for implementing the Quality Improvement, Patient Safety, and Patient Experience Plan to the hospital administration, medical staff, and its respective governance committees. Refer to Attachment A on Governance Information Flow.

The Governing Board shall require, consider, and if necessary, act upon Medical Staff reports of medical care evaluation, utilization review, and other matters relating to the quality of care rendered in the Hospital. The executive committee of the Medical Staff shall, through its chairman or designee, is responsible for the preparation and presentation of such required reports to the Governing Board at each Governing Board meeting or otherwise.

The Governing Board shall direct that all reasonable and necessary steps be taken by the Medical Staff and Hospital Administration for meeting The Joint Commission and College of American Pathology accreditation standards, California Code of Regulations including Title 22, CMS Conditions of Participation and complying with applicable laws and regulations.

Other specific responsibilities with regard to quality improvement, patient safety, and risk management are delineated in the Governing Board Rules and Regulations, which shall be reviewed and approved by the

Governing Board.

Medical Executive Committee (MEC)

According to the Bylaws of the Medical Staff, under Article 11.5, the Medical Executive Committee is responsible for the quality and effectiveness of patient care and competent clinical performance rendered by members of the Medical Staff and for the medico-administrative obligations of the medical staff.

The functions of the MEC with respect to quality include, but are not limited, to the following:

1. Fulfill the Medical Staff's responsibility of accountability to the Governing Board for medical care rendered to patients in the hospital;
2. Reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members and make recommendations to the governing board regarding appointments/reappointments, clinical privileges, and corrective action; and
3. Assisting in obtaining and maintenance of accreditation.

Medical Staff Departments and Divisions

The unified El Camino Medical Staff is comprised of three Enterprise departments which are those with constituency at both campuses (including MV & LG). All departments report to an Enterprise Medical Staff Executive Committee. The current departments are; (a complete list of all subspecialties in each department is available from the Medical Staff Office.)

- Medicine to include Radiology, Emergency Medicine, Hospitalists, Psychiatry, Neurology, and Family Medicine
- Surgery to include Pathology, Anesthesia, Orthopedics, Gynecologic Oncology, Otolaryngology, Ophthalmology, Plastic Surgery, Neurosurgery, General Surgery, Urology, Cardio-thoracic surgery, and Vascular Surgery
- Maternal Child Health to include Obstetrics/Gynecology, Pediatrics and Neonatology

Each of these three departments has monthly meetings of their Executive Committees where ongoing quality improvement projects are initiated and progress reported routinely to the Quality Council.

Other specific responsibilities with regard to quality improvement are delineated in the Medical Staff Bylaws. Refer to the Medical Staff Peer Review Policy for specific departmental responsibilities regarding ongoing professional practice evaluation and focused professional practice evaluation. See Appendix A for a graphic depiction of the flow of quality information through committees and to the governing board.

Leadership and Support

The hospital and medical staff leaders have the responsibility to create an environment that promotes quality improvement through the safe delivery of patient care, quality outcomes and high customer satisfaction. The leaders promote a patient safety culture of internal and external transparency, and support the hospital's patient safety program, which seeks to create a culture that values safety, disclosure of errors, and provides for a non-punitive process. The leaders perform the following key functions:

1. Adopt an approach to quality improvement, set expectations, plan, and manage processes to measure, assess, and improve the hospital's governance, management, clinical, and support

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activities

2. Ensure that new or modified services or processes are designed well, measured, assessed, and improved systematically throughout the organization
3. Establish priorities for quality improvement and safety giving priority to high-volume, high-risk, or problem- prone processes for performance improvement activities and reprioritize these activities in response to changes in the internal and external environment
4. Participate in interdisciplinary and interdepartmental quality and safety improvement activities in collaboration with the medical staff
5. Allocate adequate resources (i.e. staff, time, and information systems) for measuring, assessing, and improving the hospital's quality performance and improving patient safety; and assess the adequacy of resources allocated to support these improvement activities
6. Assure that staff are trained in quality and safety improvement approaches and methods and receive education that focuses on safety, quality, and high reliability
7. Continuously measure and assess the effectiveness of quality and safety improvement activities, implement improvements for these activities, and ensure sustainability of improvements made
8. Reviews the plan for addressing performance improvement priorities at least annually and updates it to reflect any changes in strategic priorities

Medical Staff, Employees, and Contracted Services

Medical staff members, hospital employees and contracted services employees maintain active participation and involvement in organization-wide quality and patient safety initiatives and activities to include participating in identifying opportunities for improvement and data collection efforts, serving on multidisciplinary teams, reporting adverse events, and implementing actions to sustain improvements.

Enterprise Quality Council

The Medical Staff Bylaws describe the composition and duties of the **Enterprise Quality Council** as a combined hospital and medical staff committee that provides to the Medical Executive Committee and Quality Committee of the Board reports on the quality of medical care provided to patients at ECH by all departments, service lines and medical staff departments. It is ~~co-~~chaired by the past chief of staff, their designee, and the Chief Quality Officer. Each department and service line provide at least an annual report including data on key process indicators to the Quality Council. This report also includes an annual assessment for all direct clinical care contracts administered by the department or service line. Enterprise Quality, Safety and Experience Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly. The Council also serves as the Steering Committee for the Organizational Quality Goal, which for FY 2023 is reduction of the Hospital Acquired Conditions (HAC) Index, and receives a monthly report on the progress of the Quality Teams that work to address this goal. The Council may charter performance improvement teams to address multidisciplinary issues, hospital-wide process and system issues. The Quality Council also receives routine reports on the quality improvement activities of each medical staff department. See Attachment B: FY 23 Quality Council report schedule.

Quality Services Department

A responsibility of the Quality Services Department is to coordinate and facilitate quality management and

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improvement throughout the hospital. While implementation and evaluation of quality improvement activities resides in each clinical department, the Quality Department staff serves as internal resources for the development and evaluation of quality improvement activities. Members of this department provide leadership of and participation in several multidisciplinary teams including, but not limited to; the teams addressing the organizational quality, i.e. ERAS (Enhanced Recovery After Surgery) Team and the NV-HAP (non-ventilator hospital-acquired pneumonia) Team. The Quality Services Department also serves as a resource for data collection, statistical analysis, and reporting functions.

The Quality Services Department is also responsible for:

1. Managing the overall flow, presentation, and summarization of quality improvement activities from all departments/service lines
2. Produces and maintains two quality dashboards for the organization and the board of directors: Enterprise Quality, Safety, and Experience Dashboard, and Quarterly Board Quality Dashboard (STEEEP). See Attachments C and D.
3. Assisting hospital leaders and the medical staff in maintaining accreditations and compliance with regulatory requirements
4. Providing clinical and provider data from hospital and external registry data bases as needed for quality improvement (See Attachment E for Data Registries in use)
5. Maintaining a quality improvement and patient safety reporting calendar and communicating it to all groups responsible for quality improvement activities
6. Collaborates with the Risk Management and Patient Safety department on efforts to manage and reduce risk through Root Cause, Apparent Cause and Common Cause Analyses as responses to adverse events and near misses and events reported to regulatory agencies
7. Collaborates on performance of failure mode and effectiveness analysis (FMEA) at least every 18 months with Risk Management and Patient Safety
8. Collaborates with the Medical Staff leaders to ensure effective use of resources through the identification and sharing of "best practices"
9. Supporting Infection Prevention efforts across the Enterprise, coordination with public health, on-going infection surveillance and reporting of hospital –acquired infections and conditions
10. Managing data collection and reporting as required by regulatory agencies and the hospital's strategic plan
11. Providing data as requested to external organizations, see data provided in Attachment F
12. Providing oversight for the hospital's participation in Clinical Registries, see Appendix E for current list
13. Manages the data and reporting process for meeting the IQR CMS reporting requirements for Core Measures and eCQM measures, the MBSAQIP, and all Transfusion review and data
14. Facilitates and maintains hospital and program-specific accreditation through the Joint Commission and works closely with the California Department of Public Health (CDPH) to improve the quality of care and safety of care provided to our patients.
15. Facilitates identification of health care disparities in the patient population by stratifying quality and safety data

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Hospital Services

All ECH departments and service lines participate in the Quality Improvement Plan by establishing mechanisms that continuously and systematically evaluate the quality of specific service care processes and outcomes. Service directors and managers annually review and identify their expected quality and performance improvement efforts based on the findings of their measurement activities. Each clinical and non-clinical service is responsible for and supporting ECH completion of at least one (1) quality and performance improvement project annually that improves patient care, safety, and/or experience and demonstrates cost efficiency.

All clinical contracted services will be reviewed, evaluated, and will demonstrate a quality and performance improvement summary/assessment on an annual basis and presented to the Enterprise Quality Council.

IMPROVING ORGANIZATIONAL PERFORMANCE

Improving performance, clinical outcomes, and Patient Safety is systematic and involves a collaborative approach focused on patient and organizational functions. Quality improvement is a continuous process which involves measuring the functioning of important processes and services, and when indicated, identifying changes that enhance performance. These changes are incorporated into new or existing work processes, products or services, and performance is monitored to ensure that the improvements are sustained. Quality improvement focuses on outcomes of treatment, care, and services. Senior Leaders, Directors and Managers establish a planned, systematic, and hospital-wide approach(es) to quality improvement. These leaders set priorities for improvement and ensure that the disciplines representing the scope of care and services across the organization work collaboratively to plan and implement improvement activities.

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Priorities are based on the organization's mission, vision and values, services provided, and populations served. Prioritization of performance improvement initiatives is based upon the following criteria:

1. Serious Safety Events (SSE) and severity of adverse events and trends of events reported in the electronic adverse event reporting system
2. Results of quality improvement, patient safety and risk reduction activities
3. Information from within the organization and from other organizations about potential/actual risks to patients. (e.g., Institute for Safe Medication Practices (ISMP), California Department of Public Health (CDPH), The Joint Commission Sentinel Event Alerts)
4. Accreditation and/or regulatory requirement(s) of The Joint Commission, Title 22 (California Code of Regulations) and CMS Conditions of Participation.
5. Low volume, high risk processes and procedures
6. Meeting the needs of the patients, staff and others
7. Resources required and/or available
8. External regulatory compliance indicators, i.e. CMS Core measures, etc. See Appendix G.
9. Response to changes not only in the internal, but also in the external environment or the community it serves

Performance Processes

1. **Design**
   The design of processes is in conjunction with the organization's Strategic goals and is based on up-to-date sources of information and performance of these processes; their outcomes are evaluated on a regular basis. Design of new processes, extension of product lines, or significant change to existing functions or processes consider basic information sources. These activities are carried out collaboratively and include the appropriate departments and disciplines involved.

2. **Measurement**
   ECH collects measurement data on important processes and outcomes that have been prioritized and selected by leaders as part of the planning process. With input from senior leaders, the Governing Board sets organizational goals for quality, service and finance. The data collected for priority and required areas is used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and to sustain improvement. All levels of the organization are responsible for reviewing measurable outcomes and acting on improvement opportunities.
   Performance measures are structured to follow The Joint Commission dimensions of performance and are based on current evidenced-based information and clinical experience. Processes, functions, or services are designed/ redesigned well and are consistent with sound business practices. They are:
   a. Consistent with the organization's mission, vision, goals, objectives, and plans;
   b. Meeting the needs of individuals served, staff and others;
   c. Clinically sound and current;
   d. Incorporating information from within the organization and from other organizations about potential/ actual risks to patients;
   e. Analyzed and pilot tested to determine that the proposed design/redesign is an improvement;
   f. Incorporated into the results of performance improvement activities.
   g. Relevant quality outcomes data from public/regulatory quality reporting and quality performance programs
      Data collection includes process, outcome, and control measures including improvement initiatives. Data is collected and reported to appropriate committees in accordance with established reporting schedules. The processes measured on an ongoing basis are based on our mission, scope of care and service provided accreditation and licensure requirements, and priorities established by leadership. Data collection is systematic and is used to:
      a. Establish a performance baseline;
      b. Describe process performance or stability;
      c. Describe the dimensions of performance relevant to functions, processes, and outcomes;
      d. Identify areas for more focused data collection to achieve and sustain improvement.

3. **Analysis**
   Data shall be analyzed on an ongoing basis to identify performance improvement opportunities.

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Statistical Quality Control Techniques shall be used as appropriate. The assessment process compares data over time, reflects evidenced-based best practices and to reference databases, both internal and external to the hospital system.
a. When findings relevant to provider's performance are identified, this information is referred to the medical staff's peer review process in accordance with the Medical Staff Peer Review Policy. Department Directors shall act in accordance with Human Resources policies regarding employee performance.
b. ECH analyzes undesirable patterns or trends in performance when the following are identified, which includes, but is not limited to:

a. Performance varies significantly and undesirably from that of other organizations;
b. Performance varies significantly and undesirably from recognized standards;
c. When a sentinel event occurs;
d. Blood Utilization to include confirmed transfusion reactions;
e. Other types of safety events identified in the Safety Event Management and Cause Analysis procedure;

Improvement Model and Methodology

MODEL FOR IMPROVEMENT: This is a simple yet powerful tool designed to accelerate improvement efforts and provide better focus on what it is we are trying to improve. The model is promoted by the Institute of Healthcare Improvement as a proven improvement model, and builds on theory developed by Juran and W. Edward Deming.

Once a decision has been made to implement an improvement strategy, the organization systematically improves its performance using the Model for Improvement. Multidisciplinary Performance Improvement (PI) Teams are commissioned and use the Model for Improvement to make improvements in a specific process. Unit based PI Teams and other The Plan-Do-Study-Act (PDSA) Teams are utilized and can form on their own to address unit or department specific needs. Decisions to act upon opportunities for improvement in care or patient safety and/or investigate concerns shall be based on opportunities identified, factors involved in measurement, required resources, and the overall mission and priorities for the organization.

The model has two parts:

1. ***Three fundamental questions, which can be addressed in any order.***
    - What are we trying to accomplish?
    - How will we know that a change is an improvement?
    - What changes can we make that will result in improvement?
      This model stresses learning by testing changes on a small scale rather than by studying problems before any changes are attempted. Testing a change is not always easy. There may be unwanted side effects. The (PDSA) Cycle provides an effective framework for developing tests and implementing changes as described next.

2. ***The Plan-Do-Study-Act (PDSA) Cycle***
   The PDSA (Plan, Do, Study, Act) is a framework for an efficient trial-and-learning methodology. The cycle begins with a plan and ends with action based on the learning gained from the Plan, Do, and Study phases of the cycle. The purpose of this cycle is to test and implement changes, by planning it, trying it, observing the results, and acting on what is learned.

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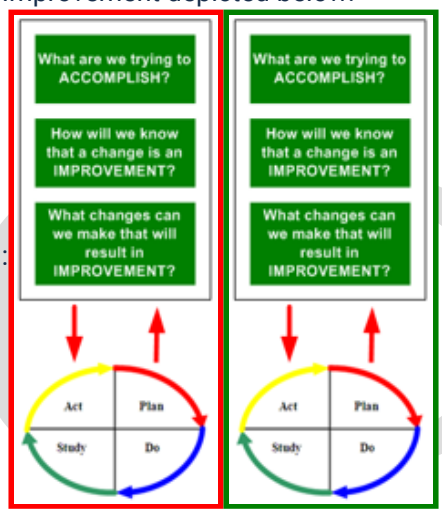
Step 1: Plan
Plan the test or observation, including a plan for collecting data. What is the objective of this improvement cycle?
Step 2: Do
Try out the test on a small scale. What did we observe that was not a part of our plan?
Step 3: Study
Set aside time to analyze the data and study the results. Complete the analysis of the data. Compare the data to your predictions. How did or didn't the results of this cycle agree with the predictions that we made earlier?
Summarize and reflect on what was learned.
Step 4: Act
Refine the change, based on what was learned from the test. Determine what modifications should be made. List actions we will take as a result of this cycle. Prepare a plan for the next cycle, if necessary. The cycle is ongoing and continuous.
In summary, combined, the three questions and the PDSA cycle form the basis of the Model for Improvement depicted below:



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3. ***Goal Setting and Auditing Methodology***

    - S.M.A.R.T. Goals: All goals should utilize the S.M.A.R.T. goal methodology so the goals can be part of every aspect of our organization and provide a sense of direction, motivation, a clear focus, and clarify importance. By setting goals for yourself, you are providing yourself with a target to aim for. A SMART goal is used to help guide goal setting. SMART is an acronym that stands for Specific, Measurable, Achievable, Realistic, and Timely. Therefore, a SMART goal incorporates all of these criteria to help focus your efforts and increase the chances of achieving that goal.
      The acronym stands for:
      S – Specific
      When setting a goal, be specific about what you want to accomplish. Think about this as the mission statement for your goal. This isn't a detailed list of how you're going to meet a goal, but it should include an answer to the popular 'w' questions:
      Who – Consider who needs to be involved to achieve the goal (this is especially important when you're working on a group project).
      What – Think about exactly what you are trying to accomplish and don't be afraid to get very detailed.
      When – You'll get more specific about this question under the "time-bound" section of

defining S.M.A.R.T. goals, but you should at least set a time frame.
Where – This question may not always apply, especially if you're setting personal goals, but if there's a location or relevant event, identify it here.
Which – Determine any related obstacles or requirements. This question can be beneficial in deciding if your goal is realistic. For example, if the goal is to open a baking business, but you've never baked anything before, that might be an issue. As a result, you may refine the specifics of the goal to be "Learn how to bake in order to open a baking business."
Why – What is the reason for the goal? When it comes to using this method for employees, the answer will likely be along the lines of company advancement or career development.

M – Measurable

What metrics are you going to use to determine if you meet the goal? This makes a goal more tangible because it provides a way to measure progress. If it's a project that's going to take a few months to complete, then set some milestones by considering specific tasks to accomplish.

A – Achievable

This focuses on how important a goal is to you and what you can do to make it attainable and may require developing new skills and changing attitudes. The goal is meant to inspire motivation, not discouragement. Think about how to accomplish the goal and if you have the tools/skills needed. If you don't currently possess those tools/skills, consider what it would take to attain them.

R – Relevant

Relevance refers to focusing on something that makes sense with the broader business goals. For example, if the goal is to launch a new product, it should be something that's in alignment with the overall business objectives. Your team may be able to launch a new consumer product, but if your company is a B2B that is not expanding into the consumer market, then the goal wouldn't be relevant.

T – Time-Bound

Anyone can set goals, but if it lacks realistic timing, chances are you're not going to succeed. Providing a target date for deliverables is imperative. Ask specific questions about the goal deadline and what can be accomplished within that time period. If the goal will take three months to complete, it's useful to define what should be achieved half-way through the process. Providing time constraints also creates a sense of urgency.

- Auditing Methodology is to ensure the process change has been hardwired and will be able to sustain the change needed for the focused improvement. This methodology will allow for a sample size to ensure the auditing has encompassed the correct % of needed audit to be statically valid.
  Measure of Success (MOS) auditing process has specified the following minimums:
  - Sample all cases for a population size of fewer than 30 cases
  - Sample 30 cases for a population size of 30–100 cases
  - Sample 50 cases for a population size of 101–500 cases
  - Sample 70 cases for a population size of more than 500 cases
  - Sample 100 cases for a population greater than 500 cases

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To ensure the methodology is a random sample the sample size should be defined in utilizing the every third or every fifth or every tenth chart or patient.

Process Improvement and the El Camino Health Operating System

ECH is on a journey of continuous improvement and operational excellence. Process Improvement is a set of concepts, principles, and tools used to create and deliver the most value from the customer's perspective while consuming the fewest resources. High Reliability Organizations deliver exactly what is needed, at the right time, in the right quantity, without defects, and at the lowest possible cost.

The Process Improvement department has been in existence since 2012, and has adopted the use of Lean methodology and principles as the foundation for our interventions. We also use tools from Six Sigma, Change Management, and PDCA, to support our transformation in becoming a High Reliability Organization. We do this by focusing on both incremental improvement over time, and breakthrough improvements all at once, with our Management System (ECHOS) as the foundation.

The Process Improvement department provides resources to the organization for problem solving, as well as deploying ECHOS, our El Camino Health Operating System. The dedicated team is comprised of Process Improvement Advisors with both clinical and industry expertise. We align our work to support and achieve the overarching Enterprise Strategic Goals. This is accomplished through large Value Stream initiatives, unit level process improvements, coaching and training ECH leaders, and partnering with all levels of the organization.

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The success of Process Improvement is dependent on robust education and training programs. Our PI Academy, a 90-day project based training program designed to encourage and support all staff to be problem-solvers, is an example of how we engage with front line staff in continuous improvement. We also provide ad hoc training sessions covering Lean/PI tools and methods throughout the enterprise to assist departments with project completion.

The Process Improvement department also has a year-long fellowship program, which has been designed to develop and grow talented, high performing and high potential leaders by providing an accelerated and intensive hands-on learning opportunity with focus on the ECHOS Daily Management and Performance Improvement Systems. Participants leave their current department and join the Performance Improvement team to gain a foundation in core management and improvement system behaviors, methods, and tools to build on their talents. They do this through high-impact assignments that help the organization drive continuous improvement to achieve the highest level outcomes across patient experience, quality, safety, affordability and physician and staff engagement.

ECHOS: El Camino Health Operating System

The El Camino Health Operating System is the framework in which we manage our business. It is comprised of the processes, methods and tools that we use to run the various functions of our work, and, includes leader behaviors that support our teams. It is the way that we lead and accomplish work at EL Camino Health. Our True North incorporates our mission, vision and values, and is supported by our True North pillars. ECHOS as our foundation, is built on the Lean principles of respect for people and pursuit of continuous improvement. These concepts, methods and tools, support our overall Daily Management System.

The Daily Management System, with our patients as the focus, has three components which define how we:

1. **Align** the goals of the organization from the Executives to the Front Line with annual *Strategy Deployment*
2. **Engage** our people in daily front line problem solving daily through the *Daily Management System* using Tiered Huddles, Linked Visual Systems, Gemba, Standard Calendar, and Leader Standard Work
3. **Continuously Improve** our processes across departments, using structure and tools that enable both local and large cross-functional processes to be improved and even transformed

Quality Improvement Link with Organizational Goals

ECH's Quality Improvement Plan focuses on specific quality measures in three areas: quality & safety, service and finance. See below for the Fiscal Year ~~2023~~2024 Organizational Performance Goals.

The organization's Quality Goals are supported by quality improvement teams composed of front line staff, managers/directors and medical staff who meet frequently to identify and address opportunities to improve the goals. In support of the Hospital Acquired Conditions Index, ECH formed ~~five~~four teams to address opportunities with ~~patient falls,~~ Hospital-acquired ~~Pressure Injuries (HAPI), Hospital-acquired~~ Pneumonia (nvHAP), C. Difficile infections, ~~and Surgical Site Infections at the beginning of the fiscal year and who meet bi~~Central Line ~~weekly: Patient Falls Committee, Skin Integrity Committee~~Associated Bloodstream Infection (~~SIC~~CLABSI), ~~Hospital~~and Cather ~~acquired Pneumonia~~Associated Urinary Tract Infection (~~HAP~~CAUTI) ~~team, and Infection Control and Prevention subcommittees for C.Diff and SSI.~~ Monthly reports on progress are provided to the Quality Council that acts as the Steering Committee for this quality goal.

Fiscal Year 2023 Performance Incentive Goal Dashboard

Pillar	Goal	Measurement Defined			
		FY 22	Minimum	Target	Stretch
Quality & Safety	HAC Index	1.066	1.013	0.986	0.959
Service	Likelihood to Recommend (LTR) – Inpatient	80.8	80.8	81.0	81.3
	LTR – El Camino Health Medical Network	74.5	83.2	83.4	84.1
People	Culture of Safety	N/A	3.99	4.02	4.04
Finance	Operating EBIDA Margin	286.0M	$114.17M	$119.88M	$125.59M

Pillar	Goal	Measurement Defined			
		FY 23	Minimum	Target	Stretch
Quality & Safety	HAC Index	1.453	1.424	1.410	1.395
Service	Likelihood to Recommend (LTR) – Inpatient	78.5	74.7	76.4	78.1
	LTR – El Camino Health Medical Network	82.7	80.0	81.3	82.6
People	Culture of Safety	3.98	3.95	4.00	4.02
Finance	Operating EBIDA Margin	256.9M	$221M	$233M	$245M

HAC Index

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

Commitment to Patient Experience

ECH has embraced the concept of an exceptional patient experience as foundational. It is our goal to form trusting partnerships among health care practitioners, staff members, and our patients and families that have been proven to lead to better outcomes and enhance the quality, safety and experience of patients and the health care team. Consequently, ECH solicits and captures feedback from a myriad of sources to ensure that the Patient/Family voice is embedded in all that we do. The comments and insights received through our feedback cards and patient satisfaction surveys are shared on a regular basis with our service lines and departments and used for recognition and improvement efforts. Understanding the experience of our

patients throughout the continuum of care is imperative as we embark on our high reliability journey. In addition to the regular feedback received through these mechanisms, ECH has also engaged prior patients to work collaboratively with our organization. The Patient and Family Advisory Council (PFAC) was established as a mechanism for involving patients and families in shared decision making as we explore performance improvement efforts, policy and program decision-making and other operational processes. The patient and family advisors partner with our various service lines and departments, providing unique perspective and aiding us in achieving the ideal patient experience. They are engaged in reviewing communication to patients and families to ensure messaging is consistent, and easily understood. Also serving as members of hospital committees, our patient and family advisors collaborate and co-design alongside our team members. They provide insights on the services they value and what is important to them as we look closely at our processes.

To deliver upon our goal for exceptional, personalized care, always, ECH established the WeCare service standards. Exceptional patient experience is not a one size fits all – it is a focus on understanding and tailoring care and services to meet patient needs and engage them as a part of the care team. The WeCare service standards highlights the importance of personalizing our interactions to help bridge relationships and establish trust. They are the framework of standards that guide behaviors and communication with our patients, their families and our colleagues. By embedding these service standards across the organization and enterprise, ECH is dedicated to provide a consistent message of compassion and respect through every interaction. Ongoing coaching, and monthly communication on the WeCare service standards has allowed this to remain at the forefront and demonstrates the emphasis and commitment ECH continues to place on delivering exceptional patient experience.

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SECTION II: Patient Safety Plan

PURPOSE

El Camino Health (ECH) is committed to the health of our community. That means we provide the highest quality, personalized care to everyone who comes through our doors — treating them not simply as a patient, but as a whole person. Fundamental to that care is our culture of Safety First/Mission Zero. In each action, decision and process, we accept nothing less than putting safety first to achieve our mission of zero harm for our patients, visitors and workforce.

El Camino Health uses the diagram above to depict the organization's Mission, Vision and Values and True North Pillars. El Camino Health is on a contuing journey to build a culture of high reliability with a focus on safety to eliminate preventable harm to patients, visitors and our workforce-what we call Safety First/ Mission Zero. El Camino Health uses the following high reliability principles to support patient safety: Preoccupation with Failure, Sensitivity to Operations, Reluctance to Simplify, and Commitment to Resilience and Deference to Expertise. El Camino Health has established leadership expectations found in Attachment H and has also established universal SAFETY skills and behaviors that all of our workforce have been trained to use to eliminate preventable harm (See Attachment I).

The intent of this Patient Safety Plan is to communicate and support our focus and commitment to providing care that is safe and compassionate while achieving optimal patient outcomes. It is designed to improve patient safety, reduce risk and promote a culture of safety that protects patients from harm. The Patient Safety Plan outlines a comprehensive program that will ensure our people, policies and procedures and performance are aligned, supports Strategic Plan priorities, the Quality Improvement Plan and ongoing quality and patient safety initiatives.

GUIDING PRINCIPLES

1. We believe that patient safety is at the core of a quality healthcare system.
2. We value the perspectives, experiences and contributions of all staff, medical staff, volunteers, patients, caregivers and the public in their role in patient safety.
3. Patient Safety is a continuous pursuit and is embedded in how we do all of our work.
4. Accountability for patient safety is everyone's business: from the Board of Directors to frontline staff to volunteers.
5. We promote a safety culture in which our workforce feel safe reporting adverse events, errors and near misses. These reports inform our improvements to care.

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6. We will foster a culture that respects diversity and inclusivity as a shared responsibility promoting access and equity for our workforce and patients.

OBJECTIVES

1. Deliver high quality safe care for every patient.
2. Engage our workforce and patients in safe practices at work at all levels of the organization using SAFETY skills (universal skills).
3. Promote a culture of safety.
4. Build processes that improve our capacity to identify and address patient safety issues.
5. Classify patient safety events and perform cause analysis to better undertand cauess of errors and areas of improvement using the root cause or apparent cause analysis tools as delineated in the Safety Management and Cause Analysis procedure.
6. Educate workforce, patients and caregivers about the Patient Safety program and initiatives that are aimed at improving patient safety and preventing harm.
7. Encourage organizational learning about medical/health care errors.
8. Incorporate recognition of patient safety as an integral job responsibility.
9. Encourage recognition and reporting of medical/health care errors and risks to patient safety without judgment or placement of blame.
10. Collect and analyze safety data, evaluate care processes for opportunities to reduce risk and initiate actions.
11. Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk.
12. Support sharing of knowledge to influence behavioral changes.

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ORGANIZATION AND FUNCTIONS

Structures that Support Patient Safety

There are a number of integral and connected structures at El Camino Hospital that address Patient Safety.

Governing Board

The Governing Board of El Camino Health bears ultimate responsibility for the quality and safety of patient care services provided by its medical, other professional and support staff. The Board shall delegate responsibility for implementing this Patient Safety Plan to the medical staff and hospital administration and the committees noted below.

Quality Committee of the Board

The Quality Committee of the Board oversees Patient Safety at the hospital. They review patient safety indicators on an ongoing basis and provide direction and input to senior leadership on patient safety concerns and initiatives. An annual report of the Patient Safety program, which includes a summary of incident reports, regulatory activity and summary of reports made to the Department of Public Health and

actions taken to address patient safety, shall be presented to the Quality Committee of the Board

Enterprise Hospital Committees

The Medical Staff Bylaws describe the composition and duties of the **Enterprise Quality Council** as a combined hospital and medical staff committee that oversees hospital patient safety related activity. Enterprise Quality, Safety and Experience Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly.

The **Enterprise Patient and Employee Safety Committee (PESC)** receives reports and monitors data from the following hospital committees and reports: Medication Safety, Falls, Pressure Injuries, Hospital-acquired Infection Teams (CAUTI, CLABSI, C. Diff), Culture of Safety surveys, National Patient Safety Goals, Safety/ Security, Leapfrog Hospital Survey and Safety Grade, Hand Hygiene, Employee Injuries and the Grievance Committee. (See Attachment G: Patient and Employee Safety Dashboard). It is a multidisciplinary committee with hospital and medical staff representation, and the minutes and dashboard are shared with Quality Council monthly. The PESC is responsible for initiating performance improvement related to patient and employee safety concerns based on identified trends and concerns. Aggregated reports of patient safety events and actions taken to promote patient safety are reported quarterly to the Patient and Employee Safety Committee.

The **Root Cause Analysis (RCA)/Cause Analysis Oversight Steering Committee** is a subcommittee and reports to the Enterprise Patient Safety Oversight Committee (PSOC). This committee is responsible for providing oversight and monitoring of the Cause Analysis program described in Safety Event Management and Cause Analysis procedure. This group is responsible for ensuring that action plans are implemented for root cause analyses and overall effectiveness of the Cause Analysis program. The **Enterprise Patient Safety Oversight Committee (PSOC)** is a hospital senior leadership committee that meets weekly to review new patient safety events and prioritize actions needed for patient safety. Information reviewed is brought forward by Risk and Patient Safety, Medical Staff leadership, Quality and Regulatory leaders. These leaders provide direction to the organization and the medical staff in addressing identified issues, problems and determine opportunities for improving patient safety.

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Patient Safety Department

El Camino Hospital has a Patient Safety Department consisting of a Director of Risk Management and Patient Safety (designated as the Patient Safety Officer), Patient Safety Manager and Patient Safety Specialists. These individuals work closely with members in the Risk Management and Quality Department on implementation of the patient safety program as described below. The Patient Safety Department works across disciplines and with team members across the organization to support and promote patient safety and drive our goal of Zero Preventable Harm.

The scope of the Patient Safety program includes the following but is not limited to:

1. Evaluation of patient safety events reported in the hospital's electronic incident reporting system to assist in assignment of Safety Event Classification pursuant to Safety Event Management and Cause Analysis Procedure.
2. Coordination of an annual Common Cause Analysis to identify trends in patient safety events and opportunities for improvement.

3. Facilitation of root cause analyses events defined in Safety Event Management and Cause Analysis Procedure.
4. Review National Patient Safety Goal (NPSG) and collaborate with Accreditation to conduct gap analyses.
5. Ongoing education and promotion of Safety First Mission Zero High Reliability Program, including development and sustainment of a Mission Zero Safety Coach and Leader Mentor program as well as development of a Patient Safety Academy.
6. In partnership with Risk Management and Quality, performance of Failure and Effects Mode Analysis (FMEA).
7. In partnership with Risk Management, implementation of performance improvement related to patient safety based on trends or needed risk mitigation.
8. Regulatory follow up needed related to patient safety
9. Promote transparency of errors and mistakes through sharing lessons learned

PATIENT SAFETY PLAN

The mechanism to ensure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines.

1. Incident reporting is a cornerstone of Safety First/Mission Zero and our Culture of Safety. Training is provided to all workforce members upon hire and with refreshers on reporting concerns using ISAFE, the hospital's electronic incident reporting system with the expectation that all workforce members (clinical and non clinical) should report safety concerns. The ISAFE system supports the documentation and tracking of patient safety incidents, findings, recommendations and actions/ improvements. The ISAFE system also allows for reporting of and follow through on feedback from staff, patients and caregivers. Our Patient Experience Office manages the Feedback reports to ensure timely response and follow-up, track and trend feedback themes and inform quality improvement opportunities.
2. Safety events are classified using the HPI methodology for safety event classification using attached algorithm (Attachment J) with identification of a Serious Safety Event Rate whose continued reduction is a strategic goal for the organization.
3. As this organization supports the concept that errors occur due to a breakdown in systems and processes and a fair and just culture, workforce members involved in an event with an adverse outcome will be supported by:
    a. A non-punitive approach and without fear of reprisal, as evidenced by the Fair and Just Culture policy.
    b. Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.
    c. Resources such as Support our Staff (SOS) or EAP should the need exist to provide support for our workforce after an event
    d. Culture of Safety surveys about their willingness to use our safety reporting systems
4. PESC Dashboard and Patient Safety Targets, Refer to Attachment G. The PESC establishes a dashboard annually to monitor patient and employee safety events with desired quality targets based on any available benchmarks and organizational goals.

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5. Patient Safety Priorities are based on the following:
    a. Serious Safety Events as identified by the Safety Event Classification team whose process is described in the Safety Event Management and Cause Analysis procedure
    b. Other patient safety events that are not classified as an SSE but raise concerns due to aggregate trend or potential for harm
    c. Information from internal assessments related to patient safety such as tracers
    d. Information from external organizations related to patient safety such as the Joint Commission Sentinel Event Alerts, ISMP
    e. Accreditation and regulatory requirements related to patient safety
    f. Fallouts from PESC dashboard.

Patient Safety Initiatives

<table>
<tr><td colspan="2">

- Safety First Mission Zero SAFETY skill program
- Safety First Mission Zero Leader Skill program which includes use of Tiered Daily Safety Huddles, Visual Learning Boards, Apparent Cause Analysis
- Hand Hygiene Audits
- Monthly Leader and Executive Rounding using 4C SAFETY skill scripts
- New hire and manager Orientation to include SAFETY skill education
- HeRO Recognition and Award Program

</td></tr>
<tr><td colspan="2">Quality Indicators of Patient Safety:</td></tr>
<tr><td>

- Nurse Sensitive Indicators (Medication Safety, Falls)
- Healthcare Associated Infections
- Surgical site infections
- Surgical Safety Checklist

</td><td>

- Pressure Injuries
- Transfusion reactions/ blood/blood product administration
- Use of Restraints
- Employee Safety
- Serious Safety Event Rate
- Culture of Safety Survey results

</td></tr>
<tr><td colspan="2">Safety Programs:</td></tr>
<tr><td>

- Central Safety Committee
- Emergency Preparedness Committee
- Infection Prevention and Control Program (including Hand Hygiene and PPE support)

</td><td>

- Antimicrobial Stewardship Program
- Radiation Safety Committee

</td></tr>
<tr><td colspan="2">Data from Environmental Safety Issues:</td></tr>
</table>

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• Product Recalls • Drug Recalls • Product/equipment malfunction	• Air Quality • Security incidents • Workplace Violence

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

Allocation of Resources

The CEO and the Senior Leadership Team provide sufficient qualified staff, time, training, and information systems to assist the Enterprise Quality Council, the Enterprise Patient and Employee Safety Committee, Medical Staff, Nursing, and Clinical Support Services in designing, implementing and maintaining effective performance improvement activities. The Directors/Managers of the organization allocate staff time to participate in performance improvement activities. Both external and internal education determined to be reflective of organizational priorities will be provided through monies allocated in expense budgets. Budgetary planning shall include resources for effective information systems, when appropriate.

Confidentiality

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The Quality Improvement & Patient Safety Program of El Camino Hospital has been designed to comply with all applicable confidentiality and privacy laws. All data, reports, and minutes are confidential and shall be respected as such by all participants in the Quality Improvement and Patient Safety Program. Confidential information may include, but is not limited to meeting minutes, electronic data gathering and reporting, serious safety event and adverse event reporting, and clinical profiling. Information may be presented to not identify specific medical staff members, patients, or other health care practitioners. These protections are provided via the Health Care Quality Improvement Act of 1986 and when applicable, California's Evidence Code 1157.

Data, reports, and minutes of the Quality Improvement and Patient Safety Program are the property of ECH. This information is maintained in the Quality, Risk Management and Patient Safety Departments and in departmental or administrative offices, as appropriate. Quality review data, reports and minutes shall be accessible only to those participating in the program. All other requests for information from the program shall be in writing stating the purpose and intent of the request, and shall be addressed to the Chief Quality Officer, Sr. Director, Quality Services Department, Director of Risk Management or Patient Safety or the Compliance Officer.

Annual Evaluation

The Chief Quality Officer or the Sr. Director of Quality Services, and the Director of Risk Management and Patient Safety shall coordinate the annual evaluation of the Quality and Patient Safety program and written plan for submission to the Enterprise Quality Council, the Medical Executive Committee and the Governing Board. The annual appraisal shall address both program's effectiveness in improving patient care, patient safety, and clinical performance, resolving problems, and achieving program objectives. The adequacy of the program, including data and information effectiveness, structure, and cost-effectiveness of the program will also be addressed.

Modifications will be implemented as needed to assure that the program is effective and efficient in monitoring patient care and clinical performance. The written plan may be modified at any time with the approval of the Quality Council, Medical Executive Committee, and the Governing Board.

Attachments

Att A Governance Information Flow~~.pdf~~

Att B Quality Council Reporting Calendar (FY~~23 Combined Quality Council Reporting Calendar rev 1.25.22.pdf~~24)

~~Att C Org Goals and Quality FY23.pdf~~

Att C Enterprise Quality, Safety and Experience Dashboard FY24

Att D Board Quality and Safety Dashboard FY~~23.pdf~~24

Att E Abbrev Registries List~~.pdf~~

Att F External Regulatory Compliance Indicators ~~2022.pdf~~2023

Att G Patient and Employee Safety ~~Committee~~ Dashboard FY24

Att H Safety First / Mission Zero Leader Skill Toolkit

Att I Safety First / Mission Zero Universal Skill Toolkit

Att J HPI Safety Event Classification Algorithm

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

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Attachments

Att A Governance Information Flow

Att B Quality Council Reporting Calendar (FY24).pdf

Att C Enterprise Quality, Safety and Experience Dashboard FY24.pdf

Att D STEEEP FY24Q1 for Board

Att E Abbrev Registries List

Att F External Regulatory Compliance Indicator 2023

Att G Patient and Employee Safety Dashboard FY24

Att H Safety First / Mission Zero Leader Skill Toolkit

Att I Safety First / Mission Zero Universal Skills Toolkit

Att J HPI Classification Tools for SEC

Approval Signatures

Step Description	Approver	Date
Quality Committee	Michael Coston: Director Quality and Public Reporting	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	02/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	11/2023
Quality Council	Michael Coston: Interim Regulatory Accreditation and Licensing Con [PS]	11/2023
Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst [PS]	11/2023
	Heidi Yamat: Director AR&L and Public Reporting	10/2023

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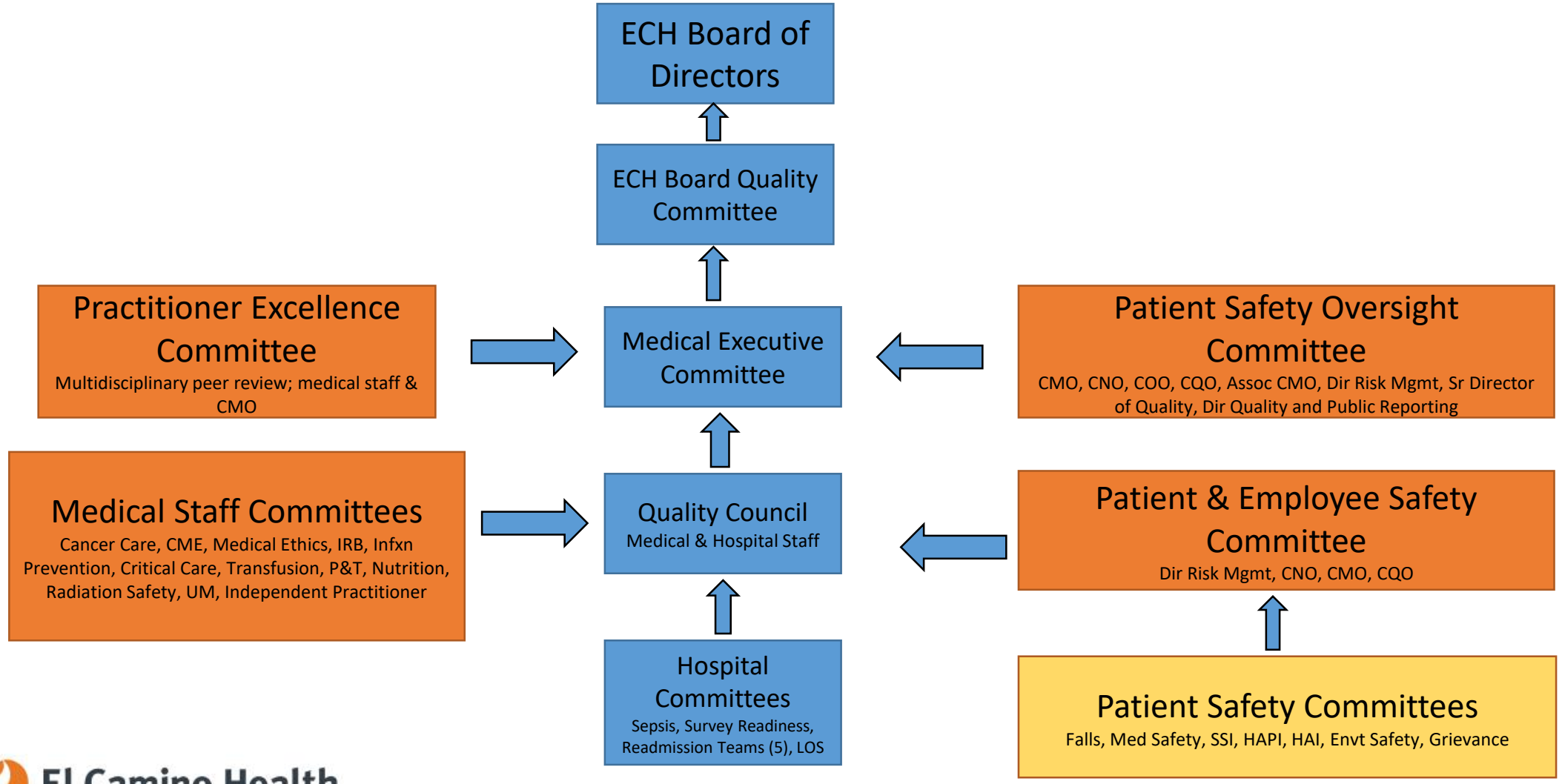
Quality Assurance and Performance Improvement—Governance Information Flow FY23



El Camino Health

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FY 24 Quality Council

Annual Performance Improvement Reporting Calendar for

Hospital Departments/Programs/Service Lines

1st Wednesday – 7:00 am to 9:00 am

2023	**July 5, 2023**	**August 2, 2023**	**September 6, 2023**
		• Health Information Management • Orthopedics Service Line • Patient Experience (HCAHPS)	• Antibiotic Stewardship • Nutrition Services • Pharmacy • Heart/Vascular Institute • Quality Improvement & Patient Safety (QIPS) Plan
	October 4, 2023	**November 1, 2023**	**December 6, 2023**
	• MV Emergency Department • LG Emergency Department • ED Physician Service Contract Evaluation • Information Services • Care Coordination	• Cancer Service Line • Human Resources • Maternal Child Health Service Line	• Urology Service Line • Sleep Center • Respiratory Care Services • Spine Service Line
2024	**January 3, 2024**	**February 7, 2024**	**March 6, 2024**
	• Rehab Service • Mental Health & Addiction Service Line • Environmental Services	• Infection Prevention • Acute Dialysis • Critical Care / Intensive Care • Organ Donation/Donor Network	• Sepsis • Acute Rehab • Patient Blood Management
	April 3, 2023	**May 1, 2024**	**June 5, 2024**
	• Imaging Services / Radiology • Contract Services • Sterile Processing • Value Based Purchasing	• Core Measures • CPR • Laboratory & Pathology • Utilization Management	• Palliative Care • MV Peri-Operative Services • LG Peri-Operative Services • Stroke Program

El Camino Health

Annual Reports

- Acute Dialysis
- Acute Rehab
- Antibiotic Stewardship
- Cancer Service Line
- Care Coordination
- Contracted Services
- Core Measure
- CPR
- Critical Care / Intensive Care
- Emergency Dept. (MV & LG)
- Emergency Dept. Physician Services Contract Evaluation
- Environmental Services
- Health Information Management (HIM)
- Heart & Vascular Institute
- Human Resources
- Imaging Services / Radiology
- Infection Prevention
- Information Services
- Laboratory & Pathology
- Maternal Child Health Services Line
- Mental Health & Addiction Service Line
- Nutritional Services
- Organ Donation/Donor Network
- Orthopedic Service Line
- Palliative Care
- Patient Blood Management
- Patient Exp. (HCAHPS)
- Peri-Operative Services (MV & LG)
- Pharmacy
- Quality Improvement & Patient Safety (QIPS) Plan
- Rehab Services
- Respiratory Care Services
- Sepsis
- Sleep Center
- Spine Service Line
- Sterile Processing
- Stroke Program
- Urology Service Line
- Utilization Management
- Value Based Purchasing

Standing Items

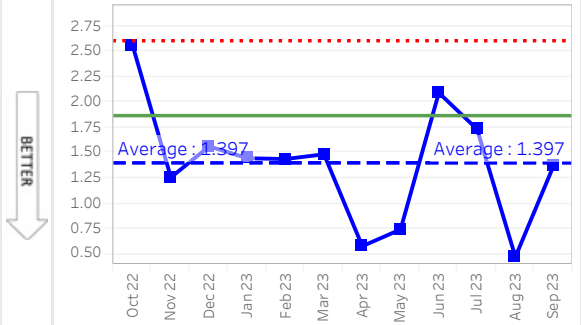
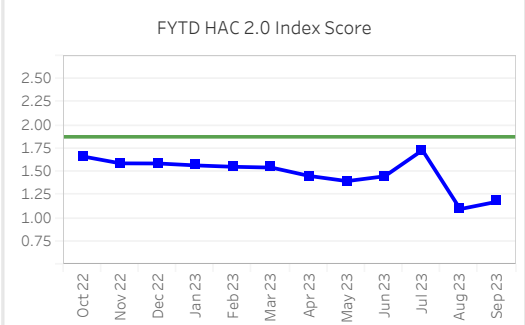
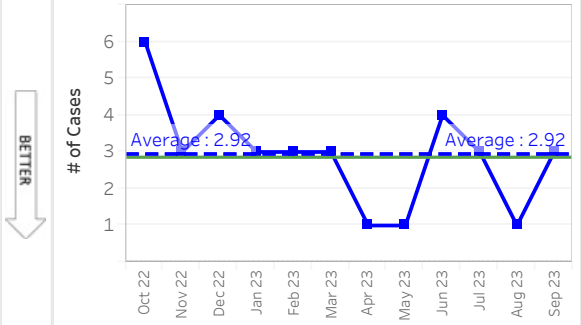
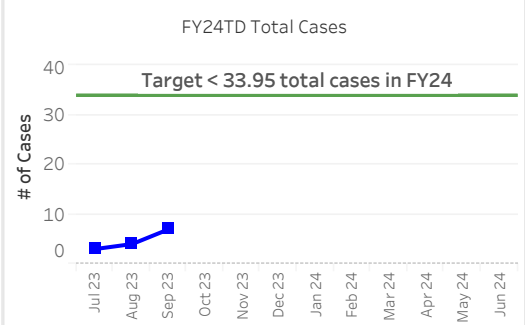
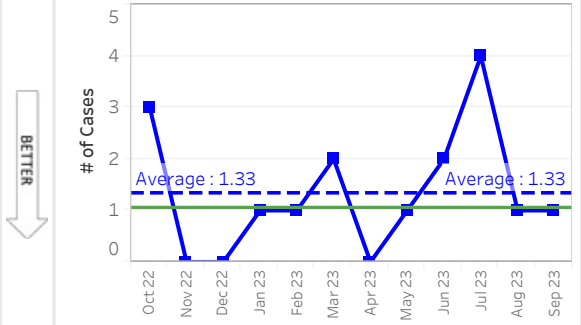
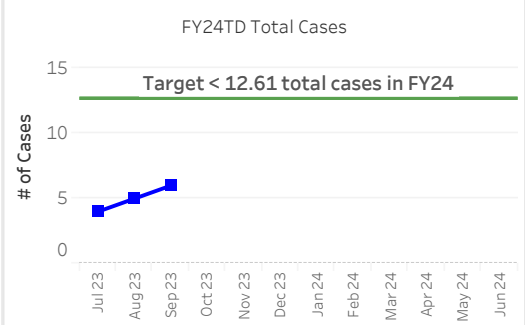
- Regulatory Update

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

September 2023 (unless other specified)

Month to Board Quality Committee : November 2023

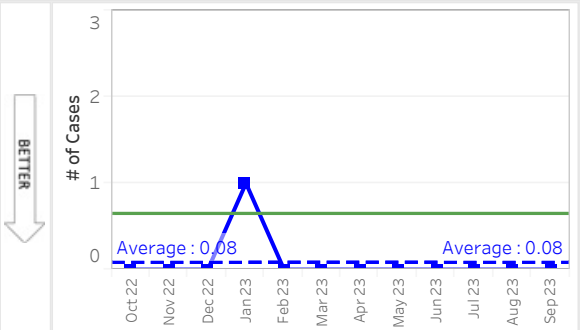
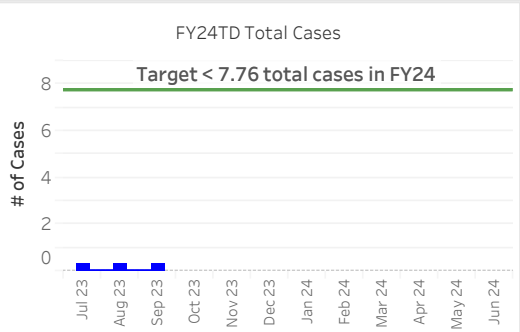
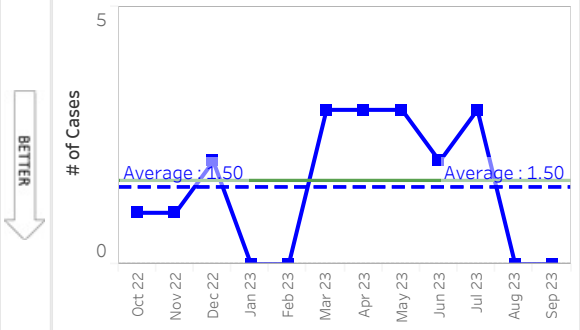
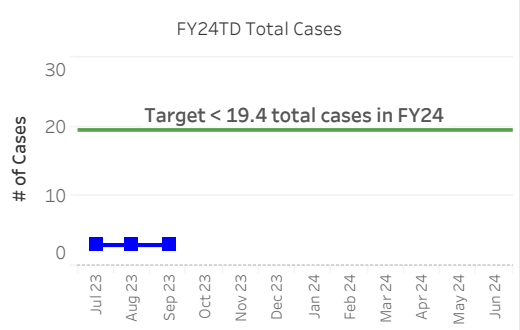
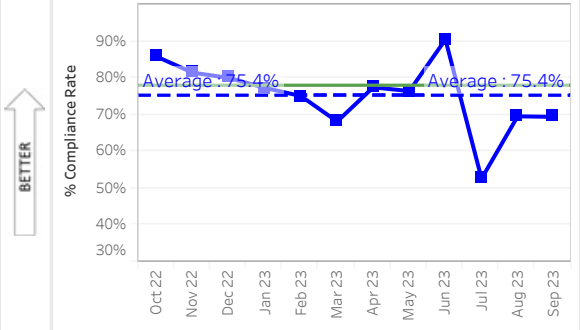
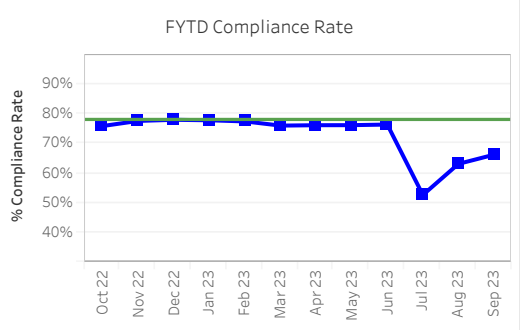
Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal HAC Index 2.0 Latest Month : September 2023	1.377	1.180	1.453	1.410 (3.0% ↓)		
HAC Component Clostridium Difficile Infections (C-Diff) Latest Month : September 2023	3 cases	2.33 cases/mo	2.92 cases/mo	2.83 cases/mo		
HAC Component Catheter Associated Urinary Tract Infection (CAUTI) Latest Month : September 2023	1 cases	2.00 cases/mo	1.08 cases/mo	1.05 cases/mo		

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

September 2023 (unless other specified)

Month to Board Quality Committee : November 2023

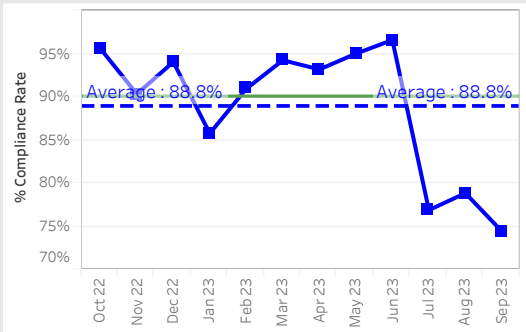
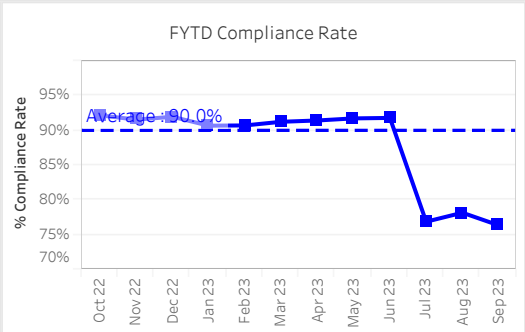
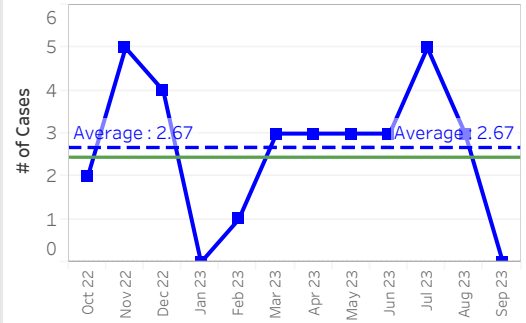
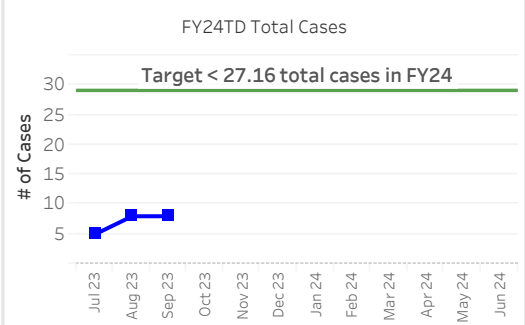
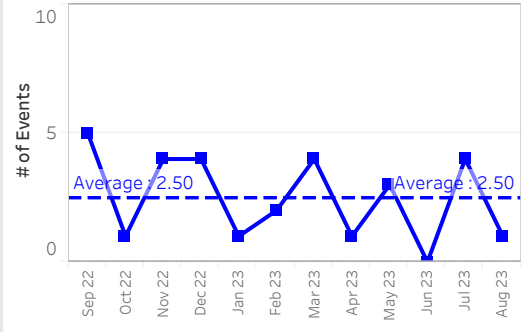
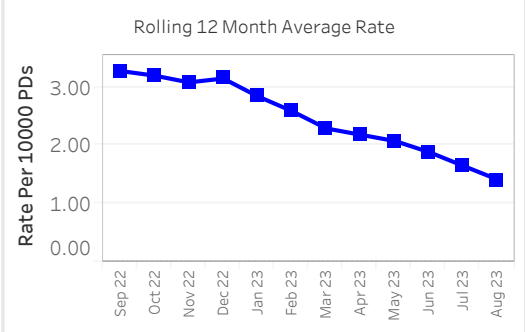
Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
HAC Component Central Line Associated Blood Stream Infection (CLABSI) Latest Month : September 2023	0 cases	0.00 cases/mo	0.67 cases/mo	0.65 cases/mo		
HAC Component non-ventilator Hospital-Acquired Pneumonia (nvHAP) Latest Month : September 2023	0 cases	1.00 cases/mo	1.67 cases/mo	1.62 cases/mo		
Hand Hygiene (Entry) Compliance % Latest Month : September 2023	69.5%	66.3%	76.5%	78.0%		

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

September 2023 (unless other specified)

Month to Board Quality Committee : November 2023

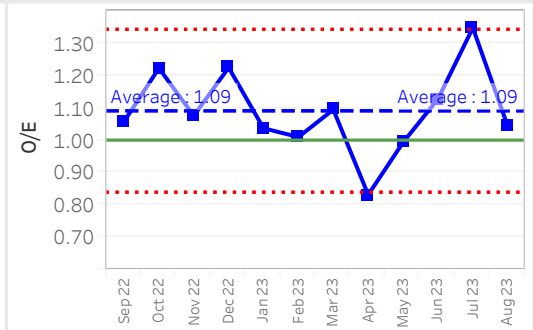
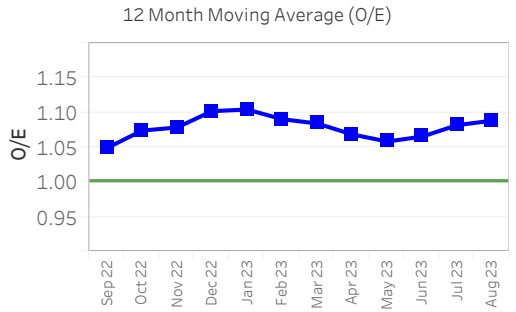
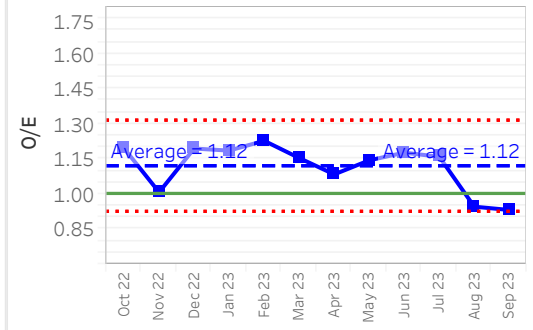
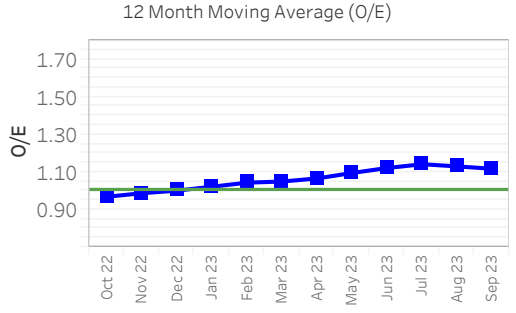
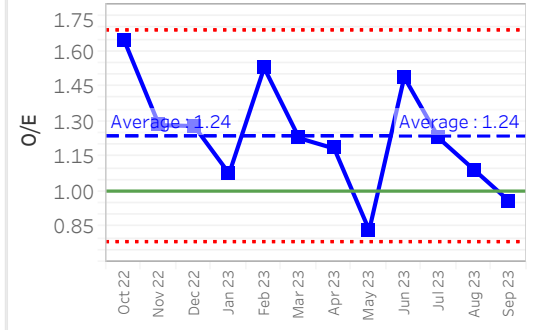
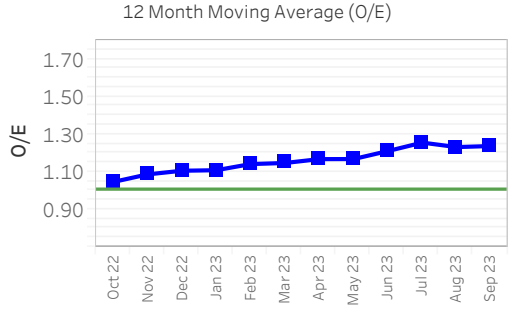
Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Hand Hygiene (Exit) Compliance % Latest Month : September 2023	74.4%	76.4%	91.8%	90.0%		
Surgical Site Infections (SSI) Latest Month : September 2023	0 cases	2.67 cases/mo	2.50 cases/mo	2.42 cases/mo		
Serious Safety Event Rate (SSER) Latest Month : August 2023	1 events	1.42 (5 / 35222)	1.88 (40 / 212460)	n/a		

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

September 2023 (unless other specified)

Month to Board Quality Committee : November 2023

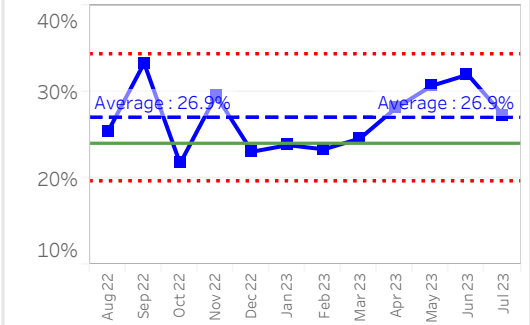
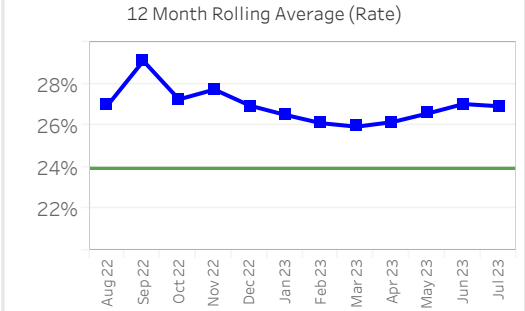
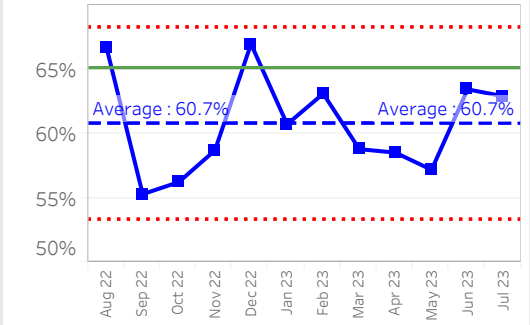
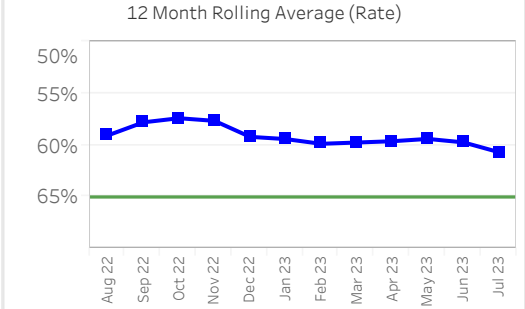
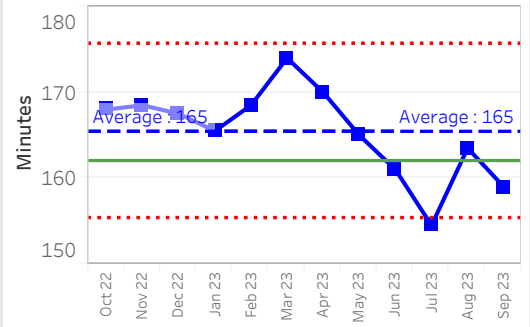
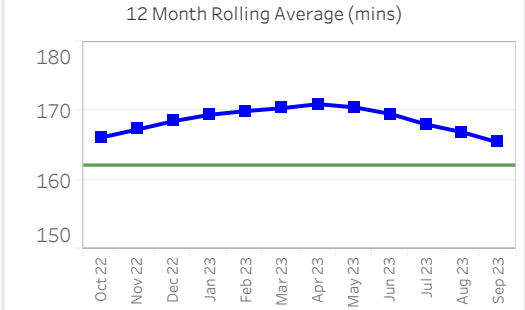
Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Readmission Index (All Patient All Cause Readmit) Observed / Expected Premier Care Sciences Standard RA Latest Month : August 2023	1.04 (8.60% / 8.25%)	1.19 (9.84% / 8.27%)	1.07 (8.47% / 7.94%)	1.00		
Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : September 2023	0.93 (1.91% / 2.05%)	1.00 (1.86% / 1.86%)	1.13 (2.21% / 1.96%)	1.00		
Sepsis Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : September 2023	0.96 (10.98% / 11.44%)	1.08 (12.09% / 11.23%)	1.21 (14.07% / 11.59%)	1.00		

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

September 2023 (unless other specified)

Month to Board Quality Committee : November 2023

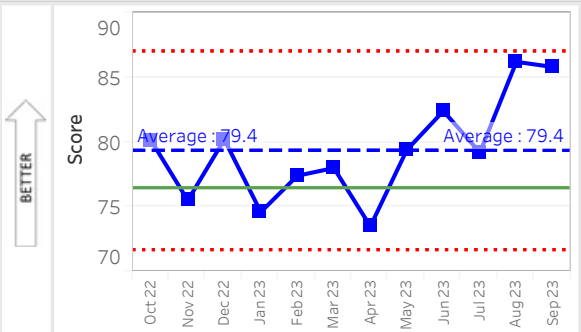
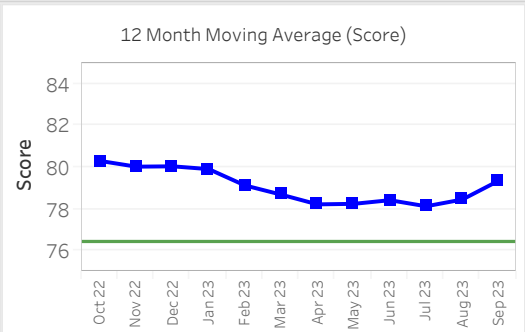
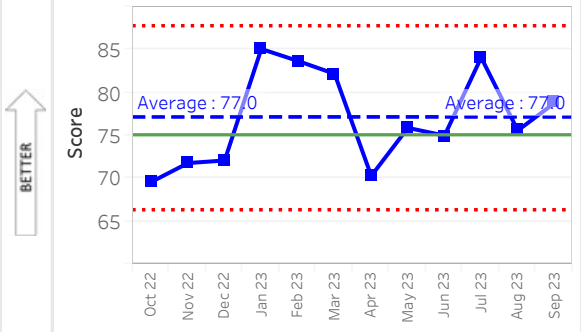
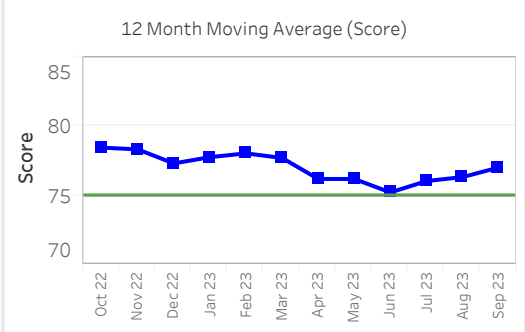
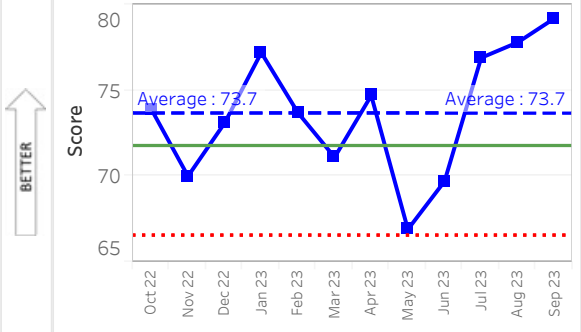
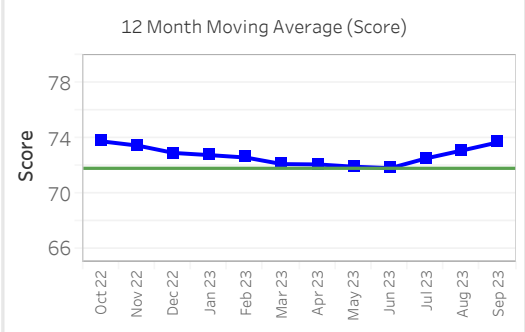
Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
PC-02 : Cesarean Birth	MV : 29.0% (45 / 155)	MV : 29.0% (45 / 155)	MV : 28.1% (530 / 1883)	23.9% (FY24 ENT Target)		
	LG : 16.0% (4 / 25)	LG : 16.0% (4 / 25)	LG : 20.1% (65 / 323)			
Latest Month : July 2023	ENT : 27.2% (49 / 180)	ENT : 27.2% (49 / 180)	ENT : 27.0% (595 / 2206)			
PC-05 : Exclusive Breast Milk Feeding	MV : 61.3% (179 / 292)	MV : 61.3% (179 / 292)	MV : 58.1% (1966 / 3385)	65.1% (FY24 ENT & MV Target) 70.0% (FY24 LG Target)		
	LG : 71.7% (38 / 53)	LG : 71.7% (38 / 53)	LG : 68.3% (427 / 625)			
Latest Month : July 2023	ENT : 62.9% (217 / 345)	ENT : 62.9% (217 / 345)	ENT : 59.7% (2393 / 4010)			
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)	MV : 186 mins	MV : 184 mins	MV : 197 mins	MV : 191 mins		
	LG : 132 mins	LG : 134 mins	LG : 142 mins	LG : 133 mins		
Latest Month : September 2023	ENT : 159 mins	ENT : 159 mins	ENT : 170 mins	ENT : 162 mins		

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

September 2023 (unless other specified)

Month to Board Quality Committee : November 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : September 2023	85.8	84.0	78.5	76.4		
IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : September 2023	78.8	79.7	75.0	75.0		
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : September 2023	79.2	77.9	71.7	71.7		

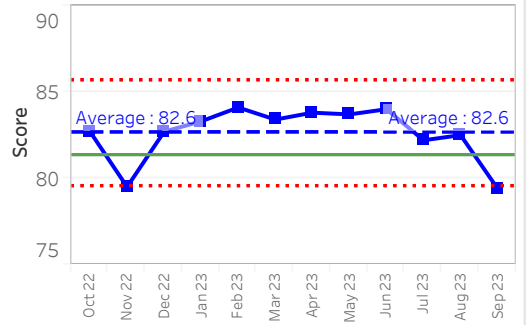
El Camino Health

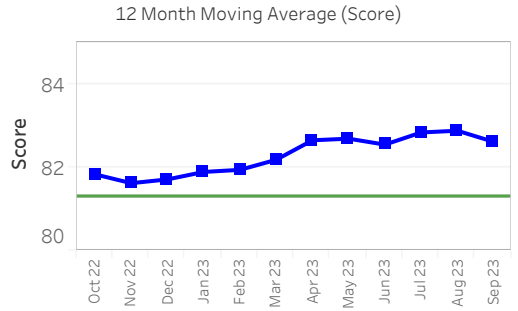
FY24 Enterprise Quality, Safety and Experience Dashboard

September 2023 (unless other specified)

Month to Board Quality Committee : November 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal ECHMN (El Camino Health Medical Network) Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : September 2023	79.4	81.6	82.7	81.3	BETTER	BETTER





Month to Quality Committee of the Board: November, 2023

El Camino Health

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	FYTD
Safe Care	HAC Index 2.0 Score		1.364	1.805	1.458	1.140	1.453	**1.410**	1.180	**1.180**
	HAC Component: Cdiff Weighted (35%) Rate (per 10,000 Patient Days)		0.878	1.631	1.223	0.881	1.162	**1.128**	0.908	**0.908**
	HAC Component: CAUTI Weighted (*15%*) Rate (per 1,000 Urinary Catheter Days)		0.081	0.097	0.131	0.106	0.103	**0.100**	0.214	**0.214**
	HAC Component: CLABSI Weighted (15%) Rate (per 1,000 Central Line Days)		0.307	0.000	0.048	0.000	0.093	**0.090**	0.000	**0.000**
	HAC Component: nvHAP Weighted (*35%*) Rate (per 1000 Patient Days)		0.098	0.077	0.056	0.153	0.096	**0.093**	0.058	**0.058**
	SSI Rate (per 100 surgical procedures) *(not part of HAC Index)*		0.314	0.552	0.196	0.463	0.380	**0.369**	0.463	**0.463**
Timely	Lab STAT Troponin TAT for ER (received to verification)		93.8%	88.8%	70.9%	78.0%	82.7%	**90.0%**	84.2%	**84.2%**
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)		78.4%	78.3%	78.3%	77.0%	78.0%	**84.0%**	76.3%	**76.3%**
Effective	Risk Adjusted Readmissions Index		1.09	1.05	1.18	1.05	1.07	**1.00**	1.19* (July-Aug)	**1.19* (July-Aug)**
	Risk Adjusted Mortality Index		1.14	1.19	1.14	1.03	1.13	**1.00**	1.00	**1.00**
	Risk Adjusted Sepsis Mortality Index		1.15	1.26	1.37	1.02	1.21	**1.00**	1.08	**1.08**
	PC-02 NTSV C-Section		28.8%	24.7%	24.0%	30.2%	27.0%	**23.9%**	27.2%	**27.2%**
Efficient	Length of Stay O/E		1.19	1.16	1.22	1.19	1.19	**1.15**	1.19	**1.19**
	Median Time from ED Arrival to ED Departure (Enterprise)		176 min	168 min	169 min	165 min	170 min	**162 min**	184 min	**184 min**
Equitable	Homeless Discharge Documentation Compliance		----	'----	----	'----	----	**----**	N/A	**N/A**
	Quality Council Health Equity Item Included in PI efforts (% of depts)		----	----	----	----	----	**----**	0.0% (0/7)	**0.0% (0/7)**
	Sepsis Bundle Compliance by Race	Asian	----	----	----	----	----	**----**	72.7%* (July-Aug)	**72.7%* (July-Aug)**
	Sepsis Bundle Compliance by Race	Hispanic	----	----	----	----	----	**----**	87.5%* (July-Aug)	**87.5%* (July-Aug)**
	Sepsis Bundle Compliance by Race	White	----	----	----	----	----	**----**	90.2%* (July-Aug)	**90.2%* (July-Aug)**
	Sepsis Bundle Compliance by Race	Others	----	----	----	----	----	**----**	50.0%* (July-Aug)	**50.0%* (July-Aug)**
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend		79.9	78.8	76.6	78.4	78.5	**76.4**	84.0	**84.0**
	ED - Likelihood to Recommend (PG)		70.3	72.3	73.8	70.4	71.7	**71.7**	77.9	**77.9**
	MCH - HCAHPS Likelihood to Recommend		72.3	72.1	83.7	74.0	75.0	**75.0**	79.7	**79.7**

Updated: 10/23/23

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

Legend:

Green: At or exceeding target

Yellow: Missed target by 5% or less

Red: Missed target by > 5%

White: No target

El Camino Hospital Data Registries – March 2023 Attachment E

#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
1	CathPCI Registry®	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Assesses the characteristics, treatments and outcomes of cardiac disease patients who receive diagnostic catheterization and/or percutaneous coronary intervention (PCI) procedures	Indication (appropriateness): Patients WITHOUT Acute Coronary Syndrome: Proportion of evaluated PCI procedures that were inappropriate. Process: Proportion of STEMI patients receiving immediate PCI w/in 90' . Outcome: PCI in-hospital risk adjusted mortality (all patients); Composite: Proportion of PCI patients with death, emergency CABG, stroke or repeat target vessel revascularization; PCI in-hospital risk adjusted rate of bleeding events (all	HVI	Quarterly
2	Chest Pain-MI Registry®–(old ACTION)	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Risk-adjusted, outcomes-based quality improvement program that focuses exclusively on high-risk STEMI/NSTEMI patients AMI process and patient care	AMI/ACS process performance: Overall AMI performance composite; STEMI performance composite; NSTEMI performance composite	HVI	Quarterly
3	STS/ACC TVT RegistryTM	STS (Society of Thoracic Surgeons) ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Monitors patient safety and real-world outcomes related to transcatheter valve replacement and repair procedures – emerging treatments for valve disease patients. With 30day and 1 year follow-up	Process: Length of Stay (TAVR & MitraClip)–Median Post Procedure (days) and outcome (TAVR & MitraClip): In Hospital, 30 day observed and 3-year risk adjusted mortality. Risk adjusted Stroke rate	HVI	Quarterly
4	LAAO RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Captures data on left atrial appendage occlusion (LAAO) procedures to assess real-world procedural outcomes, short and long-term safety, comparative effectiveness and cost effectiveness.	Process: Proportion of patients undergoing a LAAO procedure per CMS indications; Proportion of LAAO procedures successful and medication stredegy and outcome: Proportion of patients with a major complication either intra or post procedure and prior to discharge	HVI	Quarterly
5	AFib Ablation RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Assesses the prevalence, demographics, acute management and outcomes of patients undergoing atrial fibrillation (AFib) catheter ablation procedures.	Process: Proportion of patients undergoing procedure per indications; and outcome: complication rate	HVI	Quarterly
76	STS®- Adult cardiac Surgery	STS (Society of Thoracic Surgeons)	National quality measures and quality improvements with more than 5.8 million records.	Risk adjusted Mortality for isoCABG, isoAVR and MV procedures. Composite quality rating (star rating) for isoCABG, isoAVR and MV procedures	HVI	Quarterly
7	Centers for Medicare & Medicaid Services (CMS) Hospital IQR program	IBM Watson	CMS Required eCQM Core Measures	Quality indicators	Quality	Quarterly
8	National Healthcare Safety Network (NHSN)	CDC, CALNOC, CDPH, Leapfrog	Quality Measures, CDC's data registry for infection data	Quality indicators: Patient Safety Module: SSI Surveillance on 29 ICD10s Facwide/IRF Surveillance: MDRO's: CDIF; MRSA; CRE; VRE Device Associated Surveliace: CLABSI, CAUTI, CLIP Compliance Bundle Healthcare Personnel Safety Module: HCP	Quality; Nursing EW&HS	monthly Yearly
9	Metabolic and Bariatric Surgery Quality Improvement Program (MBSAQIP)	American College of Surgeons	Nationwide accreditation and quality improvement program for metabolic and bariatric surgery. MBSAQIP centers are accredited in accordance with nationally recognized MBS standards.	Risk adjusted, mortality and complication based on 30-day, 6 month, and 1 year follow-up. Follow-up extends through 5 years.	Quality	Rolling continuous data abstraction
10	National Stroke Registry	Get with the Guidelines (GWTG)	Nationally all Primary Stroke Centers report data for comparisons	Quality Indicators	Quality; Neuro	Quarterly
11	EMS Quality Committee	Santa Clara County	Key Stroke data submitted by all county hospitals	Quality indicators	Quality; Neuro	quarterly
12	The Joint Commission Disease Specific Certification Primary Stroke	The Joint Commission	Recertification as a Primary Stroke Center		Quality; Neuro	PRN
13	Association for Behavioral Healthcare	AABH	Outpatient behavioral Health	Patient satisfaction	Behavioral Health	Quarterly
14	BASIS 24 BASC-3	MacLean	Outcomes behavioral Health	Outcomes	Behavioral Health	rolling submission
15	California Maternity Quality Care Collaborative (CMQCC)	Hospital Collaborative	Outcomes Obstetric; California Quality Maternal Child Collaborative (maternal and neonatal data)	Outcomes	Obstetrics	Monthly
16	California Perinatal Quality Care Collaborative (CPQCC)	Hospital Collaborative	Neonatal Outcomes	Outcomes	Neonatal	Monthly

17	California Alliance for Nursing Outcomes	CALNOC	Actionable information and reearch on nursing sensitive quality indicators	Nursing indicators	Nursing	Quarterly
18	National Database of Nursing Quality Indicators	NDNQI	National data base that provides quarterly and annual reporting of structure, process and outcome indicators to evaluate nursing care at the unit leel	Nursing indicators	Nursing	Quarterly
19	American Joint Replacement Registry	American Association of Orthopedic Surgeons	Hip and Knee Replacement Case Profile data, Risk Assessment data, and Outcomes data	Case data including implants, comorbidities, hospital complications. Patient reported outcomes Survey data fro HOOS JR, KOOS JR, and PROMIS-10	Ortho Director	Rolling submission with PRO data drawn quarterly
20	The Joint Commission - Disease-Specific Certification for Total Joints, Hip Fracture, Spinal Fusion	The Joint Commission	Disease-specific (Total Joint, Hip Fracture, Spinal Fusion)		Ortho	Every two years
21	CCORP	CA state OSHA	California state mandated, any adult cardiac surgery related to CABG	Outcome (part of STS) risk adjusted mortality and stroke rate. Comparison with all other CA hospitals	HVI	biannually
22	Santa Clara County-AMI and Cardiac Arrest	Santa Clara County	Santa Clara county mandated. AMI and cardiac arrest patient	EMS process and outcome. Biannually County meeting	HVI	Quarterly
23	National Cancer Data Base/RCRS	American College of Surgeons and the American Cancer Society	Information on patients with malignant neoplastic diseases, their treatments, and outcomes. Data submitted for accreditation application and used for quality benchmarking	Outcomes	Cancer Registry	Monthly and Annually
24	State Registry/SEER	CA Cancer Registry	California state mandated, any reportable cancer cases.	New cancer cases	Cancer Registry	Monthly
25	HCAHPS	Press Ganey	Patient satisfaction survey required by CMS	Patient satisfaction	Patient Experience	2X a week Mon and Thurs
26	Hospital Based Inpatient Psychiatrics Services Core Measures, Hospital IQR program	CMS	HBIPS is just one set of core measures for TJC and CMS	Psychiatric clinical measures	Quality	Quarterly
27	MIRCal for inpatient, emergency room and ambulatory surgery coded data	Office of Statewide Health Planning and Development (OSHPD)	OSHPD state mandated report for IP, ED and AD coded cases on semiannual and quarterly basis.	Data statistics for coded/reported diagnoses, procedures and associated charges.	HIMS Coding	Semiannual for inpatient data and quarterly for ED and ambulatory data
28	Parkinsons Registry	California Department of Public Health	CPDR captures and stores informatin on all Parkinson's disease cases dagnosed or receiving treatment in California. The informaton is used to expand the understanding of Parkinson's disease to ultmately imporove thel lives of those affected.	The prohect is not a study, the enhanced data and informaiton available to better prevent, diagnose and treat Parkinson's disease.	IT Business Applications	Every month
29	Quarterly Tracking of Birth Defects - Neural Tube Defects and Chromosomal Abnormalities	California Department of Public Health Genetic Disease Screening Program	Coded cases for neural tube defects and/or chromosomal abnormalities found in fetus or infants less than one year of age.	Identifying fetus or infants less than one year with neural tube defects for clinical research.	HIMS Coding	Quarterly
30	ICAEl certification	Intersocietal Accreditation Commission	Adult Echocardiography facility standard and guidelines	Ongoing practice requirements: volume, experience, staff educations	HVI?	yearly

31	VQI (Vascular Quality Initiative)	VQI (Vascular Quality Initiative) is a collaboration of the Society of Vascular Surgery	Demographic, clinical, procedural and outcomes data for Carotid Endaarterectomy, Endovascular AAA repair and Peripheral Vascular Intervention procedures	Quality and outcome benchmarks including risk adjusted mortality with follow-up	HVI	Biannually
32	Transcatheter Valve Center Certification	American College of Cardiology	Provides external review that assists hospitals in meeting standards for multidisciplinary teams, formalized training, and shared decision-making with a focus on TVT Registry metrics and outcomes.	Process and Quality: In-Hospital, 30 day, and 1 year mortality and/or readmission, stroke rate, and bi-monthly M&M	HVI	Weekly, Quarterly, and Annual submissions
33	American Heart Association (AHA) Resuscitation Registry	Get with the Guidelines (GWTG)	GWTG-Resuscitation facilitates the efficient capture, analysis and reporting of data that empowers and supports the implementation of current guidelines, creation and dissemination of new knowledge, and development of next generation, evidence-based practice in resuscitation science.	Resuscitation Services Quality Indicators	Quality	Quarterly

EXTERNAL REGULATORY COMPLIANCE INDICATORS/MEASURES FOR CY 2023 REPORTING PERIOD ATTACHMENT F

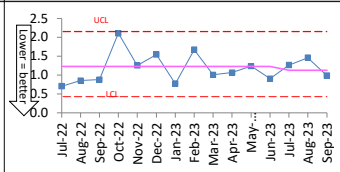
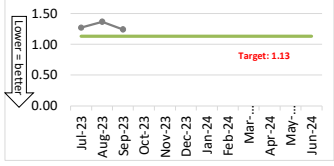
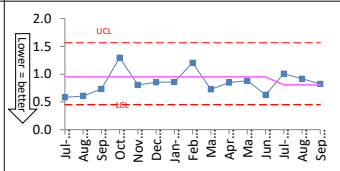
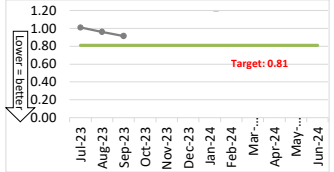
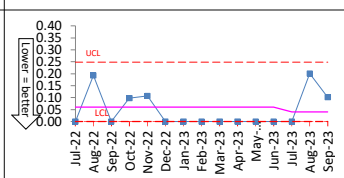
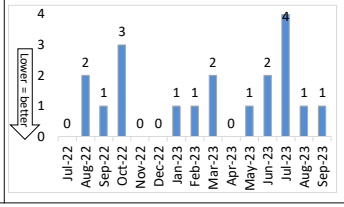
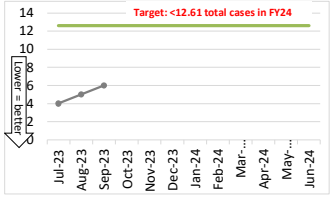
Indicator Name	Indicator Description	Regulatory/Accreditation source
Chart-Abstracted Clinical Core Measures **Hospital Inpatient and Outpatient:** * Measures Required to Meet Hospital IQR Program APU Requirements		
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	Hospital Outpatient Quality Reporting (OQR) Program
OP-23	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke	
PCB-05	Exclusive Breast Milk Feeding	TJC ORYX Performance Measurement Program
PCB-06.0	Unexpected Complications in Term Newborns - Overall Rate	
PCB-06.1	Unexpected Complications in Term Newborns - Severe Rate	
PCB-06.2	Unexpected Complications in Term Newborns - Moderate Rate	
PCM-02a	Cesarean Birth	
PCM-01 *	Elective Delivery	Hospital Inpatient Quality Reporting (IQR) Program and TJC ORYX Performance Measurement Program
SEP-1*	Early Management Bundle	Hospital Inpatient Quality Reporting (IQR) Program
SEP-3T	Sepsis Treatment 3-Hour Window	
SEP-6T	Sepsis Treatment 6-Hour Window	
SHK-3T	Septic Shock Treatment 3-Hour Window	
SHK-6T	Septic Shock Treatment 6-Hour Window	
HBIPS – Hospital-based Inpatient Psychiatric Services		
IMM-2	Influenza Immunization	TJC ORYX Performance Measurement Program
HBIPS-2	Physical Restraint	
HBIPS-3	Seclusion	
HBIPS-5a	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Overall Rate	
SUB-2	Alcohol Use Brief Intervention Provided or Offered	
SUB-2a	Alcohol Use Brief Intervention	
SUB-3	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge	
SUB-3a	Alcohol and Other Drug Use Disorder Treatment	
TOB-2	Tobacco Use Treatment Provided or Offered	
TOB-2a	Tobacco Use Treatment	
TOB-3	Tobacco Use Treatment Provided or Offered at Discharge	
TOB-3a	Tobacco Use Treatment at Discharge	

EXTERNAL REGULATORY COMPLIANCE INDICATORS/MEASURES FOR CY 2022 REPORTING PERIOD ATTACHMENT G

2022 Electronic Clinical Quality Measures (eCQM): Requirement includes three self-selected eCQMs and the Safe Use of Opioids measure for three self-selected quarters. Name and description:	**Regulatory/Accreditation source**
eVTE-1 Venous Thromboembolism Prophylaxis	Hospital Inpatient Quality Reporting (IQR) Program and TJC ORYX Performance Measurement Program
eVTE-2 Intensive Care Unit Venous Thromboembolism Prophylaxis	
eSTK-2 Discharged on Antithrombotic Therapy	
eSTK-3 Anticoagulation Therapy	
eSTK-5 Antithrombotic Therapy by the End of Hospital Day Two	
eSTK-6 Discharged on Statin Medication	
ePC-05 Exclusive Breast Milk Feeding	
eED-2 Admit Decision Time to ED Departure-Admit	
eOPI-1 Safe Use of Opioids	

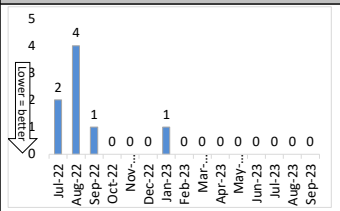
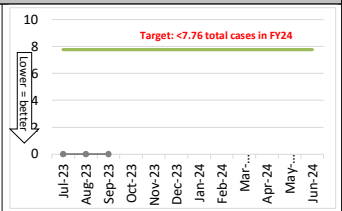
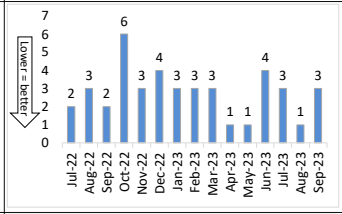
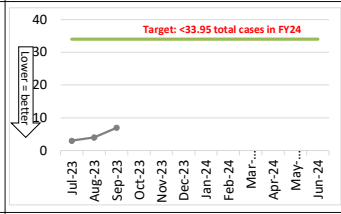
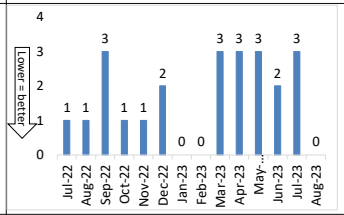
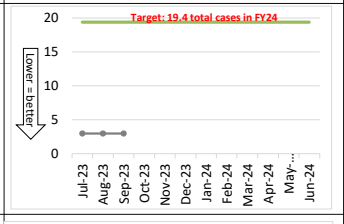
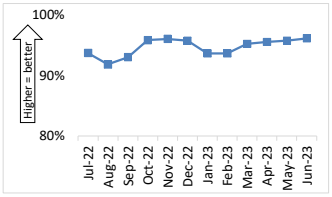
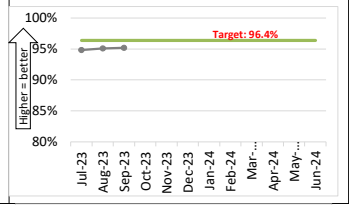
El Camino Health

FY24 Q1 Patient and Employee Safety Dashboard

	Safety Metrics	Performance: FY24 Q1	Performance: FY24: FYTD	Baseline: FY23 Actual	Target: FY24 Target/ Goal	Trend	FYTD or 12-month Rolling Average Rate	Comments	Data Owner
						Displaying at least the last 12 months of available data			
1	**IP Units area Patient Falls Reported to NDNQI** *per 1000 Patient Days (NDNQI reported)* *excludes ED, L&D, and intentional falls (ED rate calculated separately)* **Reporting Period:July - Sept 23**	1.24 (38/30637)	1.24 (38/30637)	1.17 143/122613	1.13 (139 Falls) (3%↓)			FY24 new metrics: 1.13: (139 Falls) 3% reduction.	Andria Mills
2	**All Patient Falls - Internal (ECH licensed facilities)** *All patient falls per 1000 Adjusted Patient Days (EPSI Report)* **Reporting Period:July - Sept 23**	0.92 (53/57855)	0.92 (53/57855)	0.84 194/231502	0.81 (188 Falls) (3%↓)			FY24 new metrics: 0.81: (188 Falls) 3% reduction	Andria Mills
3	**Stage 3, Stage 4 and Unstageable Hospital Acquired Pressure Injury (HAPI) Rate** (excludes skin failure and expired pts) *per 1000 Total Patient days* **Reporting Period:July - Sept 23**	0.10 (3/29895)	0.10 (3/29895)	0.04 4/100605	>= 0.04			FY24 new metrics: >=0.04	Anna Aquino
4	**HAC component** Catheter Associated Urinary Tract Infection **(CAUTI)** **Reporting Period:July - Sept 23**	6	6	13 (1.08/mo.)	12.61 (1.05/mo.) (3%↓)			FY24 new metrics: 12.61 total cases in FY24 (3% reduction of cases)	Catherine Nalesnik

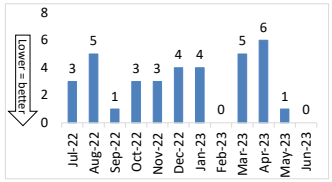
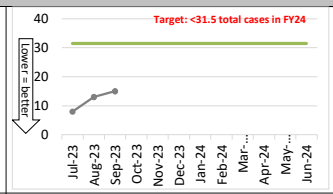
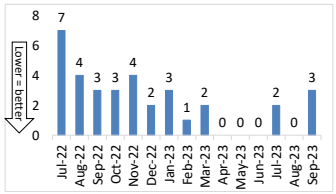
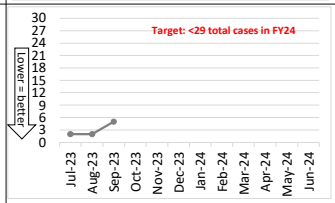
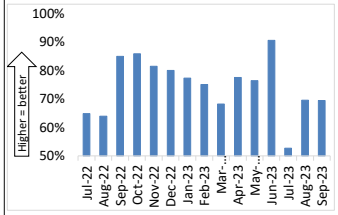
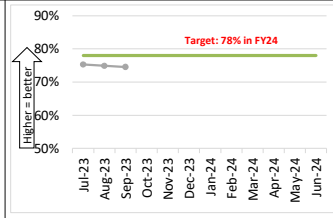
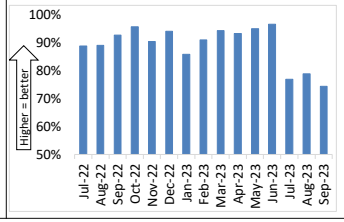
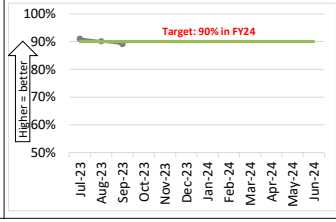
El Camino Health

FY24 Q1 Patient and Employee Safety Dashboard

	Safety Metrics	Performance: FY24 Q1	Performance: FY24: FYTD	Baseline: FY23 Actual	Target: FY24 Target/ Goal	Trend	FYTD or 12-month Rolling Average Rate	Comments	Data Owner
						Displaying at least the last 12 months of available data			
5	**HAC component** Central Line Associated Blood Stream Infection **(CLABSI)** **Reporting Period:July - Sept 23**	0	0	8 (0.67/mo.)	7.76 (0.65/mo.) (3%↓)			FY24 new metrics: 7.76 total cases in FY24 (3% reduction of cases)	Catherine Nalesnik
6	**HAC component** Clostridium Difficile Infections **(C-Diff)** **Reporting Period:July - Sept 23**	7	7	35 (2.92/mo.)	33.95 (2.83/mo.) (3%↓)			FY24 new metrics: 33.95 total cases (3% reduction of cases)	Catherine Nalesnik
7	**HAC component** **Non-ventilator Hospital-Acquired Pneumonia** *(nvHAP)* **Reporting Period: July - Sept 2023**	3	3	20 (1.67/mo.)	19.4 (1.62/mo.) (3%↓)			FY24 new metrics: 19.4 total cases (3% reduction of cases)	
8	**Blood Transfusion Completed** within 4hrs of Issue Time % **Reporting Period:July - Sept 23**	95%	95%	95.8%	↑96.4%			FY24 new metrics: The FY2024 will be over 96.4% (2% improvement from Avg. of FY 2023: 94.6%)	Jeong Chae

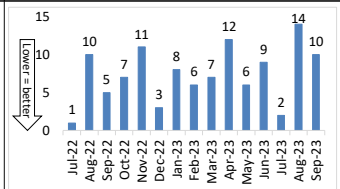
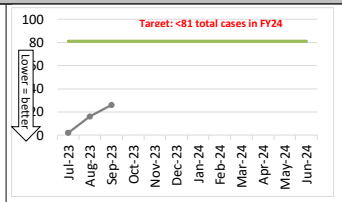
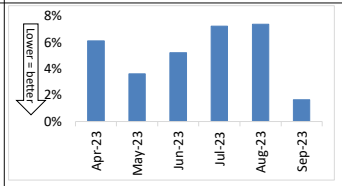
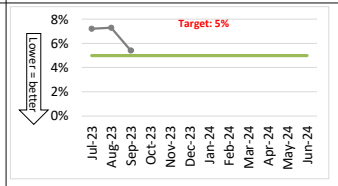
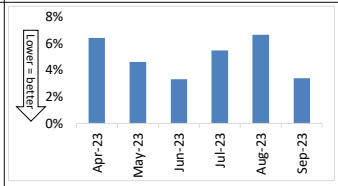
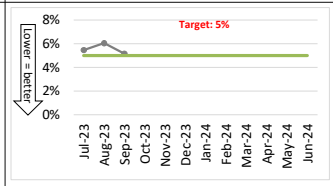
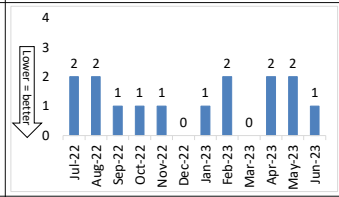
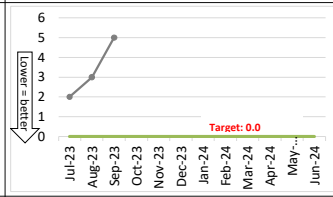
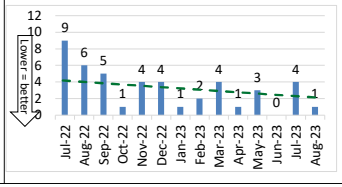
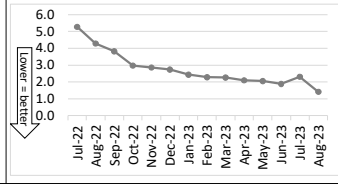
El Camino Health

FY24 Q1 Patient and Employee Safety Dashboard

	Safety Metrics	Performance FY24 Q1	Performance FY24: FYTD	Baseline FY23 Actual	Target FY24 Target/ Goal	Trend	FYTD or 12-month Rolling Average Rate	Comments	Data Owner
						Displaying at least the last 12 months of available data			
9	**Number of employee Bloodborne Pathogen Exposures (BBPE).** Reporting Period:July - Sept 23	15	15	35 (2.92/mo)	31.5 (2.63/mo.) (10% ↓ from FY23)			FY24 new metrics: The FY2024 will be 31.5 (10% decrease from Avg. of FY 2023: 35)	Michael Rea
10	**Employee Safety: # of Workplace Violence OSHA Reportable Incidents** *# of incidents* Reporting Period:July - Sept 23	5	5	31 (2.58/ mo)	29 (2.42/mo.) (6.4% ↓ from FY23)			FY24 new metrics: new target would be less than 29 or 6.4 %.	Matthew S.
11a	**Hand Hygiene Compliance (Entry) %** Reporting Period:July - Sept 23	66.3% 2649/3996	66.3% 2649/3996	Entry: 76%	Entry: 78%			Hand Hygiene at entry improves FY 23 from 76% to FY 24 to 78%	Lynn Garrett
11b	**Hand Hygiene Compliance (Exit) %** Reporting Period:July - Sept 23	72.5% 3291/4309	72.5% 3291/4309	Exit: 90%	Exit: 90%			Hand Hygiene at exits is consistent at 90% (FY 23 ended at 91%)	Lynn Garrett

El Camino Health

FY24 Q1 Patient and Employee Safety Dashboard

	Safety Metrics	Performance: FY24 Q1	Performance: FY24: FYTD	Baseline: FY23 Actual	Target: FY24 Target/ Goal	Trend	FYTD or 12-month Rolling Average Rate	Comments	Data Owner
						Displaying at least the last 12 months of available data			
12	**Medication Safety:** Medication Errors involving High Risk High Alert Medications **Reporting Period:July - Sept 23**	26	26	85 (7.08/mo)	81 (5%↓ 6.75/mo.)			FY24 new metrics: 5% reduction is 4.	Poopak Barirani
13	**Lab Safety:** Phleb + RN Draws # of Recollected due to Clotted Samples). **Reporting Period:July - Sept 23**	6.04% 33/546	6.04% 33/546	5.5%	<5% of lab draws			FY24 new metrics: <5% of draws in the NICU being recollected due to clotting (Phleb + Lab Combine)	John Mercado
14	**Lab Safety:** Phleb + RN # of Draws in NICU by Lab Staff (MV). **Reporting Period:July - Sept 23**	5.3% 21/397	5.3% 21/397	5.5%	<5% of lab draws			FY24 new metrics: <5% of draws in the NICU being recollected due to clotting (Phleb + Lab Combine)	John Mercado
15	**Never Events Reported to CDPH Rate** (includes expired patients) *per 1000 Adjusted Patient Days* **Reporting period: July - Sept 23**	5	5	15 (1.25/mo.)	0.0				Heidi Yamat
16	**Serious Safety Event Rate (SSER)** # of events/ FYTD = rolling 12 month per 10,000 Acute Adjusted Patient Days *Rate* **Reporting period: July - Sept 23**	5 *as of Aug 23	5 *as of Aug 23	1.21 40/329416					Sheetal Shah

Safety First / Mission Zero:
Our High Reliability Leader Toolkit

At El Camino Health, we are committed to eliminating preventable harm to patients, visitors, employees and medical staff. To achieve our goal of providing consistently safe and error-free care, we will lead the way to extending Safety First/Mission Zero behaviors and tools to every action, both strategic and tactical, from the front line to the executive level.

Leader Skills	Leader Methods
Living the Safety Message	• Start every meeting with a safety message • Put safety first in decision making • Protect those who speak up for safety
Leading Safe and Reliable Operations	• Tiered daily safety huddles • Top 10 safety list • Real-time simulation and testing
Building Engagement and Accountability	• 4 Cs to influence • 5:1 feedback • Fair and just culture
Finding Problems and Fixing Causes Together	• Learning boards • Apparent cause analysis • Sharing lessons learned

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Universal Skills Toolkit

I commit to Safety First/Mission Zero behaviors and tools for our patients, families, visitors and colleagues.

safety firstmission zero

S **Speak Up for Safety**	• Share safety concerns with your team. • Immediately notify chain of command about patient and/or workforce harm events. • Speak up using **ARCC:** **A**sk a question. **R**equest an alternative. Voice a **C**oncern: "I have a safety concern." If necessary, escalate through **C**hain of command. • Report safety concerns in appropriate **electronic reporting system**.
A **Accurate Communication**	• Communicate concerns using **SBAR**: **S**ituation – Give a brief statement of the problem. **B**ackground – Share a concise overview of the facts. **A**ssessment – Summarize relevant observations. **R**ecommendation – Provide your suggestion for addressing the situation. • Communicate using **Three-Way Repeat and Read Back**. • Use **letter and number clarification**.
F **Focus on the Task**	• Pay attention to detail, minimize distractions. • Do self checks using **STAR**: **S**top – Pause for a moment to focus your attention on the task at hand. **T**hink – Consider the action you are about to take. **A**ct – Concentrate and carry out the task. **R**eview – Check to make sure that the task was done correctly.
E **Embrace a Questioning Attitude**	• Use **Clarifying Questions** to understand next steps. • Use **QVV** technique when you interpret information. **Q**ualify – Ask yourself if this is a good source of information. **V**alidate – Ask yourself if the information makes sense. **V**erify – If the answers to the above questions are no, check with an expert or known reference before proceeding.
T **Take Thoughtful Action**	• Have procedures in hand for high risk/complex/infrequent tasks so you can easily check what to do and ensure it is done right (**Continuous Use** • Know how to locate your reference materials such as policies, procedures and guidelines, and use when unsure of how to proceed (**Reference Use**). • Use **SORT** technique for problem solving when there is no policy or procedure for guidance. **S**tatement – What is the problem or goal? **O**ptions – What are the possible solutions? Consider consulting with experts or literature. **R**ule Out – Eliminate the improbable or impractical to select the best option. **T**ake Action and Test – Implement the selected option, check if desired result was achieved.
Y **You and Me Together**	• Use **Cross Check** and provide on the spot second opinions. • Use the **Five Tones** in all interactions. Smile and greet others (say hello). Introduce yourself using your preferred name and explain your role. Listen with empathy and an intent to understand. Communicate the positive intent of your actions. Provide opportunities for others to ask questions.

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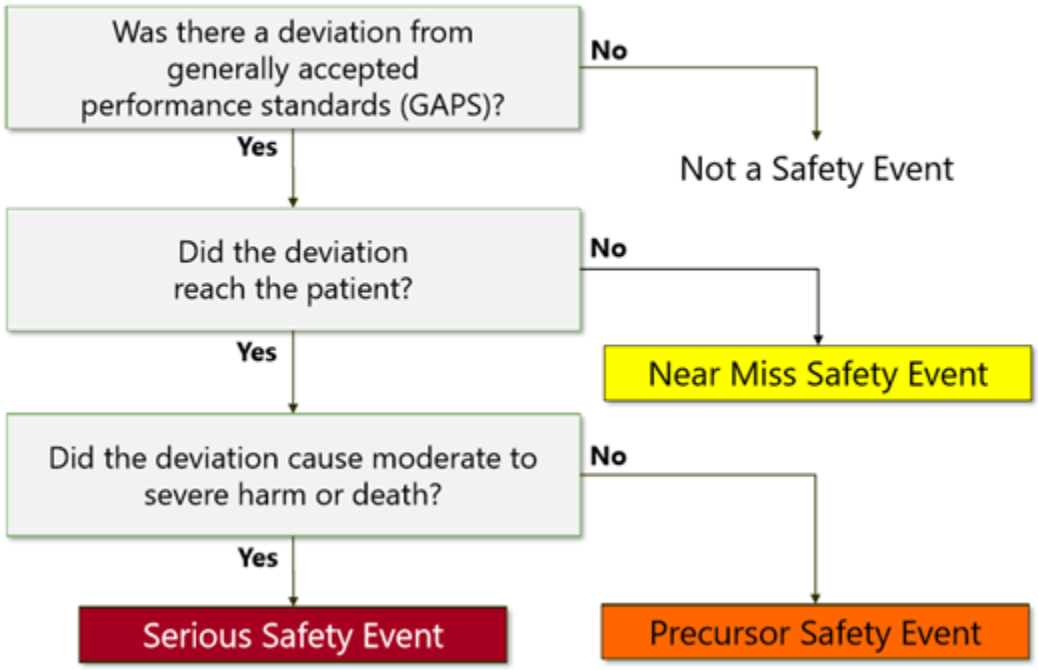
Safety Event Decision Algorithm



A deviation from generally accepted performance standards (GAPS) that...

SEC SAFETY EVENT CLASSIFICATION
HPI PRESS GANEY

Serious Safety Event
- Reaches the patient
- Results in moderate to severe harm or death

Precursor Safety Event
- Reaches the patient
- Results in minimal harm or no detectable harm

Near Miss Safety Event
- Does not reach the patient
- Error is caught by a detection barrier or by chance

Table 1. HPI SEC Levels of Harm

HPI SEC	Code	Level of Harm
Serious Safety Event (SSE)	SSE 1	Death
	SSE 2	Severe Permanent Harm
	SSE 3	Moderate Permanent Harm
	SSE 4	Severe Temporary Harm
	SSE 5	Moderate Temporary Harm
Precursor Safety Event (PSE)	PSE 1	Minimal Permanent Harm
	PSE 2	Minimal Temporary Harm
	PSE 3	No Detectable Harm
	PSE 4	No Harm
Near Miss Safety Event (NME)	NME 1	Unplanned Catch
	NME 2	Last Strong Barrier Catch
	NME 3	Early Barrier Catch